# Maternal and Child Health Services
# Title V Block Grant

# State Narrative for Maryland

## Application for 2011
## Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

# Table of Contents

# I. General Requirements

## A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
***An attachment is included in this section.***

## B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

## C. Assurances and Certifications

The required assurances and certifications have been signed by Ms. Bonnie S. Birkel, Director of the Center for Maternal and Child Health and housed in the Center for Maternal and Child Health's central offices. The assurances and certifications will be made available to the Maternal and Child Health Bureau upon request.

## D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

## E. Public Input

For the Title V application, many state and local meetings involving the Center for Maternal and Child Health Programs explaining Title V and asking to log into our online survey to provide comments and input suggestions. The public is invited to review a summary MCH plan for 2011 and to comment on the State's current MCH priorities and performance measures through a web based survey. The survey tool will remain available for public comment throughout the coming year. Survey results will be reviewed and compiled bi-monthly to assist in identifying emerging MCH needs. Comments and recommendations generated by the survey will be considered for incorporation into MCH needs assessment and planning efforts over the next five years. Comments will be summarized and included in next year's application. Links to both the needs assessment and the 2011 application will be available on both the CMCH and OGCSHCN Web sites.

For the Title V Needs Assessment, copies of a 15 page summary of the needs assessment process and the eight selected priority needs were distributed to 200 MCH stakeholders participating in the stakeholder survey and stakeholder meeting and to the Parents Place listserv. Responses thus far have been received from 25 individuals representing a broad range of groups including state agencies, the Maryland Academy of Pediatrics (MD-AAP) and local health departments.

Parents of CSHCN from The Parents' Place of Maryland were participants in preparation and review of the CSHCN portions of the block grant application.

Commnets have been incorporated into the needs assessment report. Additional input will be sought through regional meetings in the fall.

# II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

***An attachment is included in this section.***

## C. Needs Assessment Summary

The 2010 Title V Needs Assessment is attached in section III and contains the full, comprehensive assessment for Maryland.

***An attachment is included in this section.***

# III. State Overview

## A. Overview

Maryland has been aptly described as "America in Miniature." Although a small state in size and population, Maryland has great geographic and demographic diversity. This diversity creates unique challenges for the health care system in Maryland and barriers to care for many Maryland residents. The State is characterized by mountainous rural areas in the western part of the State, densely populated urban and suburban areas in the central and southern regions along the I-95 corridor between Baltimore and Washington D.C., and flat rural areas in the eastern region. This region is called "the Eastern Shore," referring to its location on the Eastern Shore of the Chesapeake Bay, the largest estuary in the U.S. The Bay is a treasured geographic asset but the fact that it bisects the state presents special challenges for Eastern Shore residents. Maryland is comprised of 24 political jurisdictions -- 23 counties and the City of Baltimore. Nine of the counties are on the Eastern Shore.

The racial/ethnic distribution of the Maryland population of 5.6 million is equally diverse: White (64.1%), Black or African American (30.0%), Asian or Pacific Islander (5.4%), and American Indian (<1%). Nearly 7% of the population (6.7%) is comprised of individuals of Hispanic origin. Minorities represented 42% of the State's 2008 population of 5.6 million. Latinos continue to be the fastest growing racial/ethnic group, representing over 6% of the State's 2008 population. While nationally, the majority of Hispanics migrates from Mexico, Maryland's Hispanic immigrants are predominantly from South and Central America. Racial/ethnic minorities now represent a majority of the babies born in Maryland (54.2% in 2008). Minority populations in Maryland continue to grow as the State's white population declines. Maryland's undocumented immigrant population is estimated to be 250,000 (Pew Hispanic Center 2008).

The prevalence and impact of health disparities continue to be significant nationally and in Maryland. The 2008 National Healthcare Disparities Report from the Agency for Healthcare Research and Quality states that nationally, 60% of disparities in quality of care measures are either not improving or actually getting worse over time. In Maryland, racial and ethnic minority disparities exist for ten of the 14 leading causes of death. Areas of significant disparity include infant mortality, maternal mortality, child deaths, cardiovascular disease, cancer, diabetes, HIV/AIDS, kidney disease, asthma, health insurance coverage, ability to afford health care, and utilization of mental health services. Maryland's high infant mortality and persistent racial/ethnic disparities in infant mortality continue to be major challenges. In 2008, Maryland's infant mortality rate was 8.0 infant deaths per 1,000 live births, virtually unchanged since 1998 and ranking Maryland 39th in the U.S. African American infant deaths occur at more than double the rate of White, Hispanic, and Asian infant deaths in Maryland.

An estimated 1.2 million of Maryland's 5.6 million residents are women of childbearing age (ages 15-45) according to the most recent U.S. census (2008) estimates. The State's 1.5 children and adolescents ages 0-19 include: 296,425 young children under the age of five; 361,155 elementary school aged children ages five to nine; and 773,937 adolescents ages ten to 19. Another 377,174 Marylanders were young adults ages 20-24. Senior citizens aged 65 and over, represented 11.4% of the population.

Maryland's workforce is one of the best educated in the nation. Over a third of Maryland's population aged 25 and older held a bachelor's degree or higher in 2008. More than 146,455 businesses employ 2.29 million workers. Of those employed in 2008, 72% of people were private wage and salary workers; 23% were federal, state or local government workers; and 5% were self-employed. Health care represents a $38.5 billion industry in Maryland with per capita spending on health care reaching $6,374 in 2007. Hospital care represented the largest category of expenditures and accounted for one-third of expenditures in 2007.

As one of the wealthiest states in the nation, Maryland had the second lowest poverty rates, both

overall and among children in 2008. However, poverty rates in Maryland continue to vary by age, race/ethnicity and jurisdiction. U.S. Census estimates for 2008 indicate that 8.2% of Marylanders were poor. Poverty rates ranged from a high of 23.1% in Somerset County to a low of 4.3% in Howard County. An estimated 137,831 Maryland children ages 0-17 (10.4%) lived in poverty in 2008. By jurisdiction, child poverty rates ranged from a high of 27.9% in Somerset County to a low of 4.9% in Howard County. The state's median household income stood at an estimated $70,482 in 2008 and by jurisdiction ranged from a high of $101,876 in Howard County to a low of $39,426 in Somerset County.

Despite Maryland's continued relative affluence, the current recession has had a profound impact in Maryland, particularly in state government where revenue shortfalls have left a $700 million budget deficit. As a result, local health department funding was cut by 45% between FY 2009 and FY 2011 which has necessitated lay-offs that include local MCH staff. A state government "temporary salary reduction plan" (mandatory furlough days) has been in effect for two years. Health clinicians (physicians, nurse-midwives, nurse-practitioners and physician's assistants) working in state facilities were exempt in FY 2009 but there have been no exemptions in FY 2010 or in FY 2011.

Health care workforce shortages/distribution affects many Maryland communities. Twenty-two of Maryland's 24 jurisdictions are currently either entirely or partially federally designated as medically underserved areas for primary care services. These shortage areas exist even though the ratio of primary care physicians to the population is higher in Maryland than the national average. This shortage is thought to be due to the high number of Maryland physicians employed by government research facilities, the military and medical schools in non-direct health care positions. Four of Maryland's 24 jurisdictions are currently classified as being underserved for dental health services/manpower and six jurisdictions are classified as underserved for mental health services. Federally qualified community health centers are located in 18 jurisdictions.

Maryland has 34 birthing hospitals, with only two nurse-midwife operating birthing centers. The distribution and level of care among the birthing hospitals is unusual -- there are 7 Level I facilities, 11 Level II facilities, and 16 Level III facilities. The voluntary Maryland Perinatal System Standards further distinguish the Level III hospitals into Level IIIA, IIIB, and IIIC. All but two of the Level III facilities are in the Baltimore or Washington D.C. metropolitan areas. Maryland's all-payer rate setting system for hospitals, in place for thirty (30) years, is the only such system in the U.S.

In spite of Maryland's relative affluence and significant health care assets, health indicators for the State remain mixed. In the 2009 Kids Count Data Book (Annie E. Casey Foundation), Maryland ranks 25th on ten indicators of child well-being. According to the 2007 National Survey of Children's Health, the prevalence of children aged 0-17 years who have special health care needs is 20.1% in Maryland, higher than the national prevalence of 19.2%. Obesity and obesity-related illnesses such as type 2 diabetes are documented to be increasing among children and adolescents. The 2005 needs assessment reported that health providers and school health personnel were increasingly identifying depression and mental health disorders as problems among adolescents. In the 2010 needs assessment, these same health concerns continue to affect Maryland children. However, progress has been made on many fronts. Fewer women are smoking during pregnancy and more are initiating breastfeeding in the early postpartum period. Teen birth rates as well as child and adolescent death rates continue to decline. More children are being screened for lead exposure and fewer are being found with elevated blood lead levels. There are fewer uninsured children and more young children are being fully immunized. Fewer adolescents are smoking and juvenile arrests for violent crimes are down. More detailed MCH-related health status indicators are reported on in the other Narrative Sections and/or the Health Status Indicator Section. Emerging health trends, problems, gaps and barriers are also identified in the 2010 Needs Assessment Report.

State Health Priorities

In August 2009, Governor Martin O'Malley identified the reduction of infant mortality by 10% by 2012 as one of the state's top 15 strategic policy goals through an initiative termed the Governor's Delivery Unit (GDU) Plan. The GDU Plan for infant mortality reduction builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, three jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. The DHMH Center for Maternal and Child Health (CMCH) is the lead agency with collaboration from other DHMH programs including the Office of Minority Health and Health Disparities, Medicaid, the Alcohol and Drug Abuse Administration, the Mental Hygiene Administration, WIC, and the local health departments in the three target jurisdictions, as well as the Department of Human Resources (DHR) and the Governor's Office for Children.

The Governor's initiative builds on the Babies Born Healthy Initiative using a life course approach for implementing programs and services to address the needs of women and infants prior to, during and following pregnancy. New programs and strategies will focus on the three critical periods before, during, and following pregnancy. Family planning services are being expanded in target jurisdictions to a broader Comprehensive Women's Health model, with the goal of healthier women prior to and between pregnancies. Medicaid, in collaboration with DHR, has established a new Accelerated Certification of Eligibility (ACE) enrollment process at both local health departments and local departments of social services. Medicaid coverage for pregnant women begins within 48 hours of an abbreviated application process and continues up to 90 days while a full Medicaid application is completed, with a goal of earlier entry into prenatal care. "Quickstart" prenatal care services have been established in the target jurisdictions with expanded screening and referral services and deployment of community outreach workers, with a goal of risk-appropriate early prenatal care. A standardized post-partum discharge referral process for birthing hospitals statewide is being piloted in the three target jurisdictions, assuring coordination between hospitals, providers, local health departments and community services, with a goal of risk-appropriate follow-up services for mothers and infants. Promoting "Safe Sleep" will be a key component.

Access to oral health care remains a priority for Maryland children and families. Maryland efforts to create an oral health safety net have increased significantly as a result of the tragic death of Deamonte Driver, a 12 year old Prince George's County resident, from an untreated dental abscess. This sentinel event occurred in February 2007 amid already growing concern about inadequate access to dental care. In response, DHMH Secretary John Colmers established a Dental Action Committee (DAC) which made seven major recommendations with a goal of establishing Maryland as a national model for children's oral health care. In response to DAC recommendations, the Maryland General Assembly approved an appropriation of $14 million (annually) to increase Medicaid dental rates to enhance the dental public health infrastructure and increase access to dental public health services for low-income children. Six new public health dental clinics have been established in regions of the state where there had been no dental public health program or facility. Support for school-based dental programs has been increased. By the end of 2010, residents in every Maryland jurisdiction will have access to a safety-net or school-linked dental clinic. Since July 2009, EPSDT medical providers including pediatricians and nurse practitioners are allowed reimbursement for the application of fluoride varnish to very young children not currently being seen by dentists.

Lack of health insurance coverage remains a barrier to health care for an estimated 12.9% of all Maryland residents; 9% of children and adolescents ages 19 and under are uninsured. The Medicaid Program, known in Maryland as the Medical Assistance Program, serves as the major source of publicly sponsored health insurance coverage for children and adolescents. The Maryland Children's Health Program (MCHP) began operating as a Medicaid expansion program on July 1, 1998. The MCHP program expanded comprehensive health insurance coverage to children up to the age of 19 with family incomes at or below 200% of the federal poverty level (FPL). In 2001, Maryland initiated a separate children's health insurance program expansion,

MCHP Premium. In FY 2008, 359,039 children and adolescents were enrolled in the Medicaid Program at some point during the year, while 120,906 were enrolled in MCHP. MCHP also provides insurance coverage for pregnant women with incomes between 185% and 250% of the federal poverty level. In FY 2008, Medicaid covered hospital delivery costs for approximately one-third of Maryland births.

Over the last three years, Maryland has expanded access to health insurance coverage to more than 161,000 Marylanders, 78,500 of whom are children under the Working Families and Small Business Health Coverage Act. During the 2007 Special Legislative Session, legislation was passed to extend Medicaid coverage to parents and other family members caring for children with incomes up to 116% of the federal poverty level. In FY 2009, the Medical Assistance for Families initiative was launched. On July 1, 2008, Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about $21,200 for a family of three. There is no asset limit when applying, no face-to-face interview is required and there are options to apply online, by mail or by fax.

Reducing health disparities continues to be a major priority in Maryland. In a memo sent to all DHMH employees on April 14, 2010, Secretary Colmers reiterated Maryland's commitment to addressing disparities, stating: "As Maryland prepares to implement health care reform, it is essential that we confront the disparities that plague far too many members of our minority communities. Eliminating disparities in health access and outcomes are a critical part of the DHMH mission and our day-to-day operations." The DHMH Office of Minority Health and Health Disparities (OMHHD), was established in statute by the 2004 General Assembly through enactment of House Bill 86. OMHDD has been directed by Carlessia Hussein, RN, DrPH since its inception. Dr. Hussein reports directly to Secretary Colmers, and OMHDD serves as a resource for training and consultation on minority health issues and cultural competence throughout the department, for local health departments, and for community-based organizations. OMHDD has primarily focused its efforts in the areas of cancer and tobacco which reflects a major funding source, the Cigarette Restitution Fund. OMHDD has had a number of accomplishments from its early work to reduce smoking and cancer disparities; the all-cause cancer mortality disparity was reduced by over 50% between 2000 and 2005. In 2008, OMHDD joined CMCH as a partner in the Babies Born Healthy Initiative, and more recently has become a major partner in Governor O'Malley's Infant Mortality Initiative. CMCH staff are active participants in many of OMHDD's activities. CMCH recently provided staff to OMHDD to support focus groups throughout the State concerning racial and ethnic disparities in H1N1 vaccine utilization.

Improving health care quality and controlling health care costs remain priorities. The Maryland Health Quality and Cost Council, chaired by the Lt. Governor and the DHMH Secretary, was established by executive order in 2007 to develop recommendations for improving health care quality and reducing health care costs in the State. In 2009, the Health Quality and Cost Council recommended the promotion of Healthiest Maryland, a Statewide movement to create a culture of wellness--an environment that makes the healthiest choice an easy choice. The three components of Healthiest Maryland are Healthiest Maryland Businesses, Healthiest Maryland Communities, and Healthiest Maryland Schools. Within each of the sectors, there is a peer-to-peer recruitment campaign to engage leadership and conduct an organizational assessment, referral to resources and technical assistance, and recognition of successful implementation of policies and environmental change. In addition, corresponding State-level policies and environmental changes will contribute to the culture of wellness throughout Maryland.

The Health Quality and Cost Council has identified obesity prevention as a major priority and is working with the DHMH Office of Chronic Disease Prevention (OCDP) to develop policies to promote access to healthy foods and opportunities for physical activity, particularly for populations who experience health disparities or who are at vulnerable periods in the life course. Black, Hispanic, and low-income Marylanders have higher rates of obesity, poor diet, and physical inactivity. Instilling healthy lifestyle habits in childhood is one way of forestalling the

rising rates of child and adult obesity. Women of childbearing age are another important population because a growing body of evidence demonstrates a link between fetal exposures and risk for obesity in adulthood. Three specific Healthiest Maryland objectives that are related to Maternal and Child Health are: promoting workplace wellness in industries that employ women of childbearing age, promoting lactation support in the workplace, and promoting implementation of wellness policies in licensed child care and schools. CMCH and the Maryland WIC program are partners with the Office of Chronic Disease Prevention on breastfeeding promotion and childhood obesity prevention.

In March 2010, the Governor created the Maryland Health Care Reform Coordinating Council to advise the administration on policies and procedures to implement recent and future federal health care reform legislation. The Council will make policy recommendations and offer implementation strategies to keep Maryland among the leading states in expanding quality, affordable health care while reducing waste and controlling costs. The Family Health Administration's priorities will continue to focus on strengthening programs, as well as revitalizing public health data systems, building public health partnerships (with the academic centers, professional and advocacy groups, and others), and strengthening operational aspects of public health administration (e.g., budget, personnel, procurement, legislation, information technology). In addition, a major FHA focus will be on leadership development with special attention paid to developing and mentoring the next generation of public health leaders.

Other health priorities for the State are childhood injuries, asthma, lead, obesity, depression and other mental health disorders. Injuries remain the leading cause of child and adolescent deaths. Two major environmentally linked health conditions--asthma and lead poisoning--continue as major causes of childhood morbidity. An estimated 190,000 Maryland children and adolescents have asthma. In 2007, the Maryland Legislature passed the Clean Indoor Air Act which prohibits smoking in most workplaces and resultantly reduces exposure to second hand smoke, a contributing factor to asthma for some Marylanders. In 2008, 106,452 children between the ages of 0-72 months were tested for lead exposure. Of those children, 489 (0.5%) had elevated blood lead levels of >/= 10 ug/dL. Much of the decline in blood lead levels is the result of implementation and enforcement of Maryland's "Reduction of Lead Risk in Housing" law. The law requires each pre-1950 rental dwelling to be issued a Full Risk Reduction certificate at tenant turnover.

MCH/CSHCN Program Priorities

Priorities for the Maryland Title V Program are aligned with the state priorities described above. Priorities reflect the ongoing needs assessment process and are determined in partnership between the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) in collaboration with sister programs within the Family Health Administration (FHA), other units within DHMH, other state agencies and stakeholders. There are many services for CSHCN available in the State and the OGCSHCN provides funding to a significant portion of them. The OGCSHCN and its partners work to coordinate a seamless, user friendly system. Current priorities are:

•Reducing infant mortality and racial disparities in birth outcome: Despite ongoing fiscal constraints, both the Governor and the Legislature have maintained state funding for the Babies Born Healthy Initiative. As noted above, Babies Born Healthy funding supports a new Governor's Initiative to reduce infant mortality in Maryland by 10% by 2012.

•Assuring access to family planning services: This includes assuring that the program maximizes efficiencies and minimizes costs while continuing to offer convenient no cost/low-cost services through a diverse network of providers, to reach more women in need. This is to be done without sacrificing the current level of comprehensiveness or quality of services. Family planning is a strategy for reducing infant mortality, and serves as the base for expanding services under the Governor's initiative.

•Advancing new prevention priorities in the areas of environmental health: This includes improving asthma management and promoting healthy nutrition/physical activity to address obesity and overweight across the life span. CMCH is the recipient of a CDC asthma intervention grant and also is responsible for administering the legislatively mandated Asthma Control Program.

•Early Childhood Comprehensive Systems (ECCS): CMCH administers the MCHB ECCS program and works in partnership with many state agencies in systems building activities. On July 9, 2010, CMCH submitted an application for the new Section 511 Maternal, Infant, and Early Childhood Home Visiting Program. This new federal funding will provide important support for a more fully integrated system of care aimed at improving outcomes for families.

•Adolescent health systems development: This is a developing priority for both CMCH and OGCSHCN. CMCH hopes to partner with OGCSHN, perhaps using a model similar to SECCS, to develop a comprehensive inter-agency approach for improving adolescent health.

•Strategic planning: During the coming year, CMCH and OGSHCN will collaborate on refining the five year MCH strategic plan based on the MCH Needs Assessment, with further input from local health departments, health providers, family groups, community-based organizations, advocacy groups and other MCH stakeholders.

•Epidemiological capacity: Maryland continues to face substantial gaps in data needed to assess and monitor the health of its women and children. Recommendations for additional surveillance are included in the MCH Needs Assessment.

•Strategic partnerships: In order to address CSHCN core outcomes in Maryland, the Maryland Community of Care Consortium (CoC) has created a broad alliance of diverse stakeholders to improve systems of care for Maryland CSHCN and their families. Multiple State agencies, academic and community providers of every sort, families, professional organizations, CYSHCN focused voluntary groups and community groups are engaged in collaborative efforts.

•Successful transition of all youth to adulthood: The OGCSHCN and its partners will work to improve the supports for CYSHCN approaching transition, beginning with supports for transition planning. Currently, Maryland lags behind the nation; ranking 42nd in the nation with only 38% of Maryland families of YSHCN aged 12 to 17 reporting that their child received the services necessary to make appropriate transitions to adult life.

•Improve Data Systems and Sharing: Improve state and local capacity to collect, analyze, share, translate and disseminate MCH data and evaluate programs. Maryland collects state and jurisdiction level data that would be useful to analyze and evaluate on behalf of the population of CYSHCN and other maternal and child health populations. By developing data sharing plans between agencies, Maryland will better target efforts to improve systems of care for CYSHCN and to provide timely information to stakeholders.

## B. Agency Capacity

Both the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHN), which are referred to collectively as the "MCH Program" below, share responsibility for MCH Block Grant development and implementation. The MCH Program operates within the DHMH Family Health Administration which is also home to the Maryland WIC program. Much about the MCH Program and sister programs within FHA can be found at http://fha.maryland.gov/ A new publication, Family Health Administration 2009

Accomplishments and Challenges may be downloaded at http://fha.maryland.gov/pdf/ohpp/Accomplishments_Challenges_2009.pdf. The MCH Program works extensively with state and local agencies to ensure coordination for women and children, including those with special health care needs.

The mission of the Maryland's MCH Program is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities, and strengthening the MCH infrastructure. MCH programs and services in Maryland are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. Both CMCH and OGCSHCN work collaboratively to ensure that Title V funds are administered efficiently and according to best practice standards in public health.

The MCH Program is responsible for addressing several federal and state mandates for improving the health of women and children. State statutes and regulations relevant to the capacity of the Title V MCH Block Grant Program include the following:

Diseases of Pregnancy and Childhood (Health-General Article, SS18-107, Annotated Code of Maryland) -- Directs the Secretary to devise and institute means to prevent and control infant mortality, diseases of pregnancy, diseases of childbirth, diseases of infancy, and diseases of early childhood as well as to promote the welfare and hygiene of maternity and infancy. This mandate applies to programs administered within CMCH and OGCSHCN.

Child Fatality Review Teams (Health-General Article, SSSS 5-701 et seq., Annotated Code of Maryland) -- Establishes multidisciplinary, multi-agency State and local child fatality review teams for the purpose of preventing child deaths. Administrative support is to be provided by the CMCH.

Maryland Asthma Control Program (Health-General Article, SSSS 13-1701 et seq., Annotated Code of Maryland) -- Establishes the Maryland Asthma Control Program within DHMH. The Program is administratively housed within CMCH.

Maternal Mortality Review Program (Health-General Article, SSSS13-1201 et seq., Annotated Code of Maryland) -- Establishes a program to review maternal deaths in partnership with MedChi (the State Medical Society) and provides certain immunity from civil liability and criminal disciplinary actions. Support is provided to MedChi by CMCH.

Children's Environmental Health and Protection Advisory Council (Health-General Article, SSSS13-1501 et seq., Annotated Code of Maryland) -- Creates a Council which is charged with identifying environmental hazards that may affect children's health and recommending solutions.

Lead Poisoning Screening Program (Health-General Article, SS18-106, Annotated Code of Maryland) -- Establishes a Lead Poisoning Screening Program to assure appropriate screening of children. This Program is administratively placed within CMCH.

School Health Program (Education Article, SS7-401, Annotated Code of Maryland) -- Requires the State Department of Education and the Department of Health and Mental Hygiene to jointly (1) develop public standards and guidelines for school health programs; and (2) offer assistance to the county boards and county health departments in their implementation.

Child Death Review (House Bill 705 (2009) -- Child Fatality Review - Child Death Review Case Reporting System (codified at Health-General Article, SSSS5-701 and 5-704, Annotated Code of Maryland)); COMAR10.11.05 Child Death Review Case Reporting System) -- Authorizes the members and staff of the State Child Fatality Review Team to provide identifying information related to cases of child death in Maryland to the National Center for Child Death Review

(NCCDR). The information transfer will occur in accordance with a data use agreement that requires the NCCDR to act as a fiduciary agent of the State and local Child Fatality Review Teams. The bill also outlines the confidentiality and discovery protections related to information provided to the NCCDR. CFR was established by statute in 1999 with enactment of Senate Bill 464.

Fetal and Infant Mortality Review (House Bill 535 (2008) -- Morbidity, Mortality and Quality Review Committee (codified at Health-General Article, SS18-107, Annotated Code of Maryland)); COMAR 10.11.06 Morbidity, Mortality, and Quality Review Committee -- Pregnancy and Childhood) -- Protects Fetal and Infant Mortality Review (FIMR) records from being released in a legal action and provides FIMRs immunity from civil liability and criminal disciplinary actions; establishes an infrastructure to coordinate FIMR with other related reviews such as Child Fatality Review, Maternal Mortality Review, and other reviews of morbidity and mortality associated with pregnancy, childbirth, infancy, and early childhood.

Lead Poisoning Screening Program - Implementation (COMAR 10.11.04) CMCH is administratively responsible for this program but collaborate with partners that include the Maryland State Department of Education and Department of Environment which have companion regulations.

Family Planning (Family Law Article, SS2-405, Annotated Code of Maryland) -- Requires DHMH to provide a family planning brochure which is distributed to all marriage license applicants by county clerks. CMCH's Family Planning Program is responsible for providing the family planning information required by this statute.

Perinatal Systems Standards -- the standards are "voluntary" but have been incorporated in the following regulations: COMAR 10.24.12 (State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetric Services); COMAR 10.24.18 (State Health Plan for Facilities and Services: Specialized Health Care Services -- Neonatal Intensive Care Services); COMAR 30.08.01 (MIEMSS -- Designation of Trauma and Specialty Referral Centers -- General Provisions)

Identification of Infants (Health-General Article, SSSS20-401 and 20-402, Annotated Code of Maryland) -- Specifies the types of procedures to identify a newborn infant to be used by all institutions or related facilities that deliver an infant from its mother, and specifies the information that must be included in each identification procedure and requirements for verification that the identification procedure was performed.

Family Planning Counseling and Services Referrals (Human Services Article, SS5-309, Annotated Code of Maryland) -- Requires the Department of Human Services to administer a Family Investment Program (FIP) whose purpose is to support family efforts to achieve self-sufficiency through services and financial aid geared to individual family needs. In part, FIP provides referrals to FIP recipients for family planning counseling and services, as appropriate, in a manner that is noncoercive, confidential, and does not violate the recipient's religious beliefs. CMHC's Family Planning Program provides the family planning referral information required by this statute.

Hereditary and Congenital Disorders Program (Health-General Article, SSSS13-101 et seq., Annotated Code of Maryland) -- Establishes an Advisory Council and programs to address hereditary and congenital disorders. Originally passed in 1973, this statute was amended in 2008 to put newborn screening in statute. Newborn screening was previously governed by regulations. The language added in 2008, re-establishes the State Public Health Laboratory as the sole laboratory authorized to perform first tier newborn screening, ending the problems caused by allowing a commercial laboratory to compete with the State Public Health Laboratory.

Newborn Screening (COMAR 10.52.12 Screening for Treatable Disorders in the Newborn Child) -

- Establishes a voluntary program to offer newborn screening for treatable metabolic disorders. Originally promulgated in 1975, these regulations were modernized to conform to the 2008 establishment of a Statewide system for newborn screening in statute. (see Health-General Article, SS13-111, Annotated Code of Maryland) Informed consent is no longer required for screening. The model is now informed dissent with written documentation of parental refusal. This program is jointly administered by the Laboratories Administration (lab analysis and short-term follow up) and by the OGCSHCN (long-term follow up).

Hereditary Diseases (COMAR 10.52.01 General Regulations for Hereditary Diseases) (several programs related to genetic disorders are mandated in regulation rather than statute) -- Establishes quality assurance standards for hereditary and congenital disorders services procured by the State. These regulations are administered by the OGCSHCN.

Sickle Cell Anemia (Health-General Article, SSSS18-501 et seq., Annotated Code of Maryland) -- Establishes a program for screening newborns for sickle cell anemia, monitoring each affected infant's health and providing prenatal education regarding sickle cell anemia. This program is part of the bloodspot newborn screening and follow up program. In 2006 and 2007 this statute was amended to provide for a Statewide Steering Committee to improve services for adults with sickle cell disease. Again, the program is jointly administered by the Laboratories Administration (lab analysis) and by the OGCSHCN (long-term follow up, health monitoring and health education). The Office for Minority Health and Health Disparities is also involved in the Statewide Steering Committee.

Screening for Sickle Cell Disease, Thalassemia and Related Conditions (COMAR 10.52.13) -- Establishes a voluntary program for population-based carrier screening for these conditions. This program does not include newborns or those thought to be at risk on clinical grounds. This program is administered jointly by the Laboratories Administration (lab analysis) and the OGCSHCN (health education, genetic counseling).

Screening for Neural Tube Defects in the Fetus (COMAR 10.52.14) -- Establishes a program to offer biochemical maternal serum screening to identify mothers at increased risk for carrying a fetus with a neural tube defect or a chromosomal anomaly. This program is administered by the OGCSHCN in partnership with the University of Maryland School of Medicine, Division of Human Genetics.

Program for Hearing Impaired Infants (Health-General Article, SSSS13-601 et seq., Annotated Code of Maryland) -- Establishes a program for universal hearing screening of newborns and early identification and follow-up of infants at risk for hearing impairment. This program is administratively placed in OGCSHCN. The corresponding regulations are COMAR 10.11.02 (Identification of Infants).

Birth Defects (Health-General Article, SS18-206, Annotated Code of Maryland) -- Requires hospitals to report birth defects to the Secretary. Also requires the Secretary to monitor birth defects trends. Originally passed in 1982, this statute was amended in 2008 to expand its authority to collect data on any significant birth defect, not just a list of "sentinel birth defects and to clearly establish the programs authority to review medical records. The OGCHSN is administratively responsible for the program.

Program for Crippled Children (Health-General Article, SS15-125, Annotated Code of Maryland) -- Establishes a program to identify and to provide medical and other services to "children who are crippled or who have conditions related to crippling." Administratively placed within the OGCSHCN. This is the Children's Medical Services (CMS) Program, the payer of last resort for specialty care for low income uninsured or underinsured CSHCN. The corresponding regulations, COMAR 10.11.03 (Children's Medical Services Program), are much more modern in terminology.

Center for Maternal and Child Health

The mission of the Center for Maternal and Child Health (CHMH) is to improve the health and well-being of all women, newborns, children and adolescents in Maryland. To accomplish this s mission, CMCH works in collaboration with other DHMH units, with the State agencies that comprise the Governor's Children's Cabinet, with local health departments, hospitals, FQHCs, private providers, professional organizations and community-based organizations. Overall direction and leadership for CMCH health policy development, program management, and systems improvement are provided by CMCH Director, Bonnie Birkel, and CMCH Medical Director, Dr. Lee Woods. Many MCH program priorities are cross-cutting and overlap, so there are no true "silos" within CMCH contrary to the visual image provided by the attached organizational chart.

Key MCH Program Components

CMCH works with local health department, FQHCs, and hospital to
Assuring access to maternal health services, including medical care, risk assessment, prenatal education, case management, smoking cessation counseling, genetic screening, high-risk referral, home visiting, assistance in obtaining hospital-based services, and referral for family planning, and preconception health care. In collaboration with Medicaid, CMCH supports the Toll Free Maternal and Child Health Hotline (1-800-456-8900) that is linked with the federal hotline 1-800-311-BABY.

Over half of the MCH Block Grant funding goes to support the local public health infrastructure for MCH Maryland's 24 local health departments. All but Baltimore City are considered units under DHMH authority with local health officers jointly appointed by local government and the DHMH Secretary. MCH funding is included in local health department core funds, (allocated by formula) and in categorical grants that include the Improved Pregnancy Outcomes (IPO) Program. IPO funding supports FIMRs, outreach, and enabling services. A larger MCH proportion of funding goes to Baltimore City where infant mortality, teen pregnancy, and childhood lead poisoning remain important issues.

CMCH is also working with FQHCs that do not currently provide prenatal care and/or primary prevention services for women to increase local health services capacity. Local health department were once the primary prenatal care providers for low-income and uninsured pregnant women. Their role changed to eligibility and enrollment support when the decision was made to put prenatal care into the Medicaid managed care program, HealthChoice. While virtually all pregnant women who are U.S. citizens or legal immigrants have access to prenatal care under Health Choice, approximately 5,000 Maryland births are to undocumented immigrants. This has forced many health departments to return to some level of safety net provider.

Fetal and Infant Mortality Reviews (FIMRs) have been underway in all 24 jurisdictions since 1998. FIMRs not only provide important insight into opportunities for systems improvement, they have also served as an important mechanism for local and regional communication, coordination and collaboration on other MCH issues. CMCH has several projects of "regional and state importance" that grew out of this process, including "Mom Movers" on the mid-Eastern Shore, "BabyNet" on the lower Eastern Shore which are both projects focused on improving access to care for undocumented pregnant women.

Maryland has had voluntary perinatal standards in place since 1998. The standards are periodically reviewed and updated as needed or in accord with new AAP/ACOG Guidelines for Perinatal Care. CMCH convenes and leads the Perinatal Clinical Advisory Committee (PCAC) membership is organizational and includes representation from ACOG, AAP, ACNM, AWHONN, the Maryland Hospital Association, the Maryland Patient Safety Center, MedChi, the Maryland Association of County (and Baltimore City) Health Officers, the Maryland Health Care Commission, Medicaid, the Maryland Institute for Emergency Medical Systems and Services

(MIEMSS), and the two representatives each from the academic medical institutions -- Johns Hopkins and University of Maryland. The standards were last revised and reissued in 2008.

The standards have been adopted in regulation by MIEMSS for the designation of "perinatal referral centers" -- hospitals that can receive maternal and neonatal transfers.
CMCH funds a position at MIEMSS to support this process. Hospitals requesting designation must file a lengthy application and undergo comprehensive sites reviews every 5 years that include outside experts as well as clinical staff from CMCH.

Special Initiatives/Accomplishments

In 2007, Maryland General Assembly approved an appropriation for the "Babies Born Healthy" initiative which is conducted by the Department of Health and Mental Hygiene (DHMH) Center for Maternal and Child Health (CMCH) in collaboration with the DHMH Office for Minority Health and Health Disparities. The initiative has focused on prevention services and quality improvement, with the belief that improving infant health requires a comprehensive, multifaceted approach that encompasses family, community, and systems factors associated with poor pregnancy outcomes. The initiative has advanced perinatal standards and quality improvement activities in 25 hospitals through a partnership with the Maryland Patient Safety Center. It has also been strengthening provider capacity and expertise for high risk pregnancies via telemedicine consultation in partnership with Maryland's two academic medical institutions. Women's health services have been enhanced in partnership with WIC. The Office of Minority Health and Health Disparities has established community-based coalition building activities and a pilot "perinatal "navigators" program two jurisdictions with Babies Born Health funding. As noted earlier in the narrative, the Babies Born Healthy Initiative has served as the important base for the Governor O'Malley's 2009 Infant Mortality as described earlier in the narrative.

The Babies Born Healthy Initiative has also provided start-up funding to the DHMH Vital Statistics Administration to implement the new web-enabled electronic birth certificate (EBC) in January 2009 for enhanced surveillance. The new EBC adopts the revised U.S. Standard Certificate of Live Birth in Maryland which includes numerous new and revised data items that are critical for public health purposes. The new system will improve the timeliness, completeness, and accuracy of vital records data, and will allow for easier electronic matching of files. One limitation, however, is that a large proportion of Maryland births occur out-of-state (primarily in Washington DC) and these will not be reported in the new system.

The Pregnancy Risk Assessment Monitoring System (PRAMS), a
CDC supported statewide survey that identifies and monitors selected maternal behaviors, has been a major source of enhanced surveillance since it's inception in 1999. The Maryland response rate is among the best of PRAMS states. The program was funded by the CDC to add additional questions to the PRAMS survey on seasonal flu and H1N1 vaccination among pregnant women. A PRAMS Data Quality Improvement Project proposed to the CDC to compare of items in PRAMS survey responses to those on medical hospital delivery charts was not funded but CMCH hopes to do this project with existing resources.

In March 2010 Amnesty International released a report entitled, "Deadly Delivery: The Maternal Health Care Crisis in the USA," stating that Maryland's maternal mortality ratio (MMR) is 16.5 deaths/100,000 births, ranked 48th among states. This report includes MMR data compiled by the National Women's Law Center, based on CDC's National Center for Health Statistics (NCHS) 1999-2004 data. As noted in the report, maternal mortality surveillance based solely on death certificates result in undercounting of maternal deaths. Maryland Maternal Mortality Reviews utilizes enhanced surveillance methods include reviewing medical examiner records and comparing the death certificates of women of reproductive age with birth certificates to establish whether a woman had given birth within a year of her death. Enhanced surveillance may identify as many as 90 percent more maternal deaths than providers reported on death certificates. CMCH's Medical Director for Women's Health, Dr. Diana Cheng, co-authored a paper with Dr.

Isabelle Horon, Director of the DHMH Vital Statistics Administration, "Intimate Partner Homicide Among Pregnant and Postpartum Women" which was published in June 2010 issue of Obstetrics & Gynecology. The article summarized pregnancy-associated homicide perpetrated by current or former intimate partners in Maryland from 1993-2008, and found it to be most prevalent among women who were African American and under 20 years of age. Homicides occurred most often during early pregnancy.

In 2008, CMCH played a major part in the establishment of an Adolescent Health Colloquium in partnership with the Johns Hopkins Center for Adolescents (CAH). Several CMCH staff were members of this group and contributed to the development of a new publication "The Teen Years Explained -- A Guide to Health Adolescent Development" published by Johns Hopkins with support from the CDC. CMCH has purchased the guide for use with local Interagency Committees on Adolescent Pregnancy. The guide can be downloaded by going to http://www.jhsph.edu/adolescenthealth/

Women's Health/and Family Planning
An important goal within CMCH's mission to improve the health of women of reproductive age by assuring that comprehensive, quality family planning and reproductive health care services are available and accessible to citizens in-need. The program provides contraceptive and reproductive health care to over 70,000 clients each year through a statewide network of over 80 ambulatory sites located in local health departments, outpatient clinics, community health centers, Planned Parenthood affiliates, and private provider offices. Family planning clinics in 3 jurisdictions are piloting an expanded model of care for more comprehensive women's health based largely on MCHB funded "Women Enjoying Life Longer (WELL) Project" in Baltimore County. Adopting a life span approach and developing new comprehensive women's health strategies is an important opportunity for both Title V-MCH and Title X-Family Planning.

Office of Genetics and Children with Special Health Care Needs (OGCSHCN)

The mission of the OGCSHCN is: (1) to reduce death, illness and disability from genetic disorders, birth defects, chronic diseases and injuries and to improve the quality of life for these individuals, and (2) to protect and promote the health of Maryland's children with special health care needs by assuring a family-centered, community-based, comprehensive, coordinated and culturally appropriate system of specialty health care. The OGCSHCN strategy is to identify CSHCN as early as possible and facilitate their access to all needed services to optimize outcomes for children and families.

Key Program Components

The OGCSHCN has very strong partnerships with the academic tertiary /specialty care centers. The OGCSHCN provides grant funding to the academic tertiary care centers to partially subsidize both genetic services and specialty care. Maryland CYSHCN primarily access services at the Johns Hopkins Medical Institutions (JHMH) including the Kennedy Krieger Institute (KKI), the University of Maryland Medical Center (UMMC) and Children's National Medical Center (CNMC). Through its Centers of Excellence Systems grant program, the OGCSHCN provides a partial subsidy to these institutions to support specialty care clinics, outreach specialty clinics, complex care management clinics, wrap around and enabling services. The grants fund a resource liaison function at each center, that is, one or more positions dedicated to assisting families to navigate the system. In terms of genetic services, the Maryland Genetics Network grants fund the academic genetics centers to provide genetic services at their institution, consultations to affiliated community institutions and to operate outreach genetics clinics in 12 locations in low population density areas of the state. The genetics grants also fund extremely specialized laboratory services that are not generally available elsewhere.

Grants to the academic medical centers also provide partial support for special clinics, such as the Comprehensive Hemophilia Treatment Center, Pediatric Sickle Cell Treatment Centers, and

Transition Clinics for youth with sickle cell disease, hemophilia and diabetes.

The OGCSHCN funds the Local Health Departments (LHD) to provide care coordination for CSHCN and respite care, to prepare regional resource directories, and to host outreach specialty clinics and outreach genetics clinics. This funding also allows for periodic needs assessments and, special projects such as the medical home project in Baltimore City.

The OGCSHCN funds 2 community partners, the ARC of Montgomery County and PACT (an affiliate of the KKI), to provide medical day care for severely involved, medically fragile, technology dependant children, 6 weeks to 5 years of age, who cannot be accommodated in typical childcare settings.

Several disease specific support groups are funded to provide peer support and to operate specialty camps that provide respite care for children with disorders such as sickle cell disease, PKU, neurofibromatosis and spins bifida. One grant partially subsidizes pre-school vision screening in Head Start programs through the Rosalie Sauber Pre-School Vision Screening Program of the Maryland Society for Sight.

The main non-state agency partner of the OGCSHCN is the Parent's Place of Maryland (PPMD), the family voices chapter for Maryland. Beginning in 1998, the OGCSHCN provided a grant to support PPMD's role in providing the family and community perspectives for policy and planning, to assist in identifying gaps in services for CYSHCN, to compile information on resources in a database and disseminate this information to parents of CYSHCN (the Family to Family Health Education and Information Center), to maintain a network of regional resource parents, to assist parents of CYSHCN to find needed resources on an individual basis and to develop parent leaders in the community. PPMD is the main partner of the OGCSHCN in trying to build the infrastructure for a comprehensive, community based, culturally competent, family centered, easy to use system of care for CYSHCN. In 2008 PPMD, in partnership with the OGCSHCN, Johns Hopkins Bloomberg School of Public Health, and the Maryland Chapter, American Academy of Pediatrics, applied for and was awarded a State Implementation Grant for Integrated Community Systems of Care for Children and Youth with Special Health Care Needs (CYSHCN) from HRSA. The major strategy was to form a "Community of Care Consortium" (CoC) to engage diverse partners in shared planning, implementation, and evaluation of strategies to achieve all 6 core outcomes for CYSHCN. Consortium partners include families, youth with special health care needs, representatives from advocacy groups, physicians, other providers, health care facilities, academic institutions, government and professional organizations, public payers, MCOs, policy analysts and state governmental agencies. The CoC has been working for almost 2 years. The CoC meets quarterly and has working committees around each of the core outcomes to evaluate strategies to and assist the members of the CoC to implement evidence based practices to improve care for CSHCN. One project to assist local pediatric practices to become better medical homes by introducing standardized developmental screening and referral into their workflow has engaged 30 practices in the Baltimore metro area and hopes to engage more practices statewide through partnerships with managed care and other practice organizations. The CoC seems to be the best mechanism to achieve the formidable task of integrating the components of the existing community based services since all stake holders are involved. PPMD and the CoC have been intimately involved with the preparation of the MCH Block Grant Application for 2 years and with the Needs Assessment this year. PPMD was represented at the MCH Block Grant review last year.

Special Initiatives/Accomplishments

In terms of the 4 constructs of a service system for CSHCN, the OGCSHCN collaborates with numerous other State agencies and private organizations, to address each level of the MCH pyramid. The OGCSHCN provides direct care services through grants to academic tertiary care centers. The system uses outreach clinics to provide care in low population density areas and works to support primary care for CSHCN. The OGCSHCN supports enabling services by directly

providing enabling services in the newborn screening program, the long term follow up program for children with metabolic disorders and sickle cell disease, the birth defects program and through subsidies to the tertiary care centers for genetic services, complex care management clinics, specialty clinics, outreach clinics and a resource liaison position at each center. OGCSHCN builds infrastructure for services to CYSHCN through partnerships (described in the partnerships section) and building an infrastructure for support of families with CYSHCN. The OGCSHCN provides partial subsidies that contribute to the infrastructure that provides medical services and enabling services as well as provides funds for the genetic services system, the specialty clinics at the tertiary care centers (Centers of Excellence), the resource liaison function at the tertiary care centers, the outreach clinic system, the local health departments, PPMD and many disease specific support groups.

The OGCSHCN works with and funds the 24 local health departments to develop regional resources, regional resource directories and systems to provide care coordination and respite care in the community. Quarterly regional meetings are held with local health departments.

CoC integrates the health components of the existing community based services. The funding of a resource liaison function at each tertiary care center assists families to navigate the system.

PPMD uses funds from the OGCSHCN, among other sources, to provide a system of regional resource parents, knowledgeable about the resources in their area. The PPMD also operates the Family to Family Health Education and Information Center. The development of regional resource directories by the local health departments is another attempt to assist families to find needed resources.

Coordination with the Maryland Department of Education assures coordination and guidance on issues involving CSHCN in: the Infant's and Toddler's Program (ITP), the Interagency Coordinating Council for ITP, the Care Giver's Support Council, care management for children with IFSPs or IEPs , education for children with hearing loss identified through infant hearing screening, the health needs of children in special education and data collection and exchange issues.

The OGCSHCN works with the Department of Human Resources (DHR) to provide support on issues of medical day care and SSI/SSDI.

This past year, in partnership with the Maryland AAP, standardized protocols for developmental screening were distributed, and medical home training activities were conducted to assist practices in coordinating services for CSHCN in their practices.

CMCH, OGCSHCN, and PPMD partnered to develop a statewide survey of parents of CYSHCN as part of the 2010 Title V Needs Assessment. Parent responses were solicited through multiple methods, including paper surveys at regional workshops across the state, in-person surveys in typically low-response areas including Baltimore City and Prince George's County, and through an online survey service. More than 950 parents responded. Preliminary data analysis was completed and incorporated in the population based reports for the Needs Assessment, and other analyses are in progress and will be disseminated to stakeholders across the state and used to direct program activities.

## C. Organizational Structure

The Department of Health and Mental Hygiene (DHMH) is one of 5 state agencies that comprise Governor Martin O'Malley's Children's Cabinet. The other agencies are the Department of Human Resources (DHR), the Maryland Department of Education (MSDE), the Department of Juvenile Services (DJS), and the Department of Budget and Management. The Children's

Cabinet is coordinated by the Governor's Office for Children (GOC). The GOC Executive Director, Rosemary King Johnston, Chairs the Children's Cabinet. DHMH is the designated agency responsible for administering Title V-Section 509 (b) as well as other Title V programs.

DHMH Secretary John M. Colmers, the former director of the Maryland Health Care Commission, was appointed by Governor O'Malley in 2007. Secretary Colmer's priorities include expanding health insurance coverage, improving the quality of health care services and controlling health care cost growth. In October 2008, Secretary Colmers named Frances B, Phillips, RN, MHA as DHMH Deputy Secretary for Public Health Services. Ms. Phillips oversees the Family Health Administration, the new Infectious Disease and Environmental Health Administration (formerly the Community Health and AIDS Administrations), the State Laboratory, the Office of Preparedness and Response, and the Office of the Chief Medical Examiner. At the same time, a new DHMH Deputy Secretary for Behavioral Health and Disabilities was established; Renata J. Henry was named as first Deputy Secretary to hold this post. Behavioral Health includes the Alcohol and Drug Abuse Administration, the Mental Hygiene Administration, and the Developmental Disabilities.

The Title V Program is within the Family Health Administration (FHA) under the direction of Russell W. Moy, MD, MPH. With the retirement of long-time Deputy FHA Director, Joan Salim, on June 30, 2010, FHA has been reorganized with two Deputy Directors. The Deputy Director for Family Health Services is David S. Long. Mr. Long now oversees the Center for Maternal and Child Health, the Office for Genetics and Children with Special Health Care Needs, and the Office of the Maryland Women, Infants and Children Program. He is also responsible for oversight of two chronic disease hospitals and legislation/regulations, and information technology within FHA. Donna Gugel is Deputy Director for Prevention and Disease Control which includes the Center for Cancer Surveillance and Control, the Center for Health Promotion, Education and Tobacco Control, and the Office of Chronic Disease Prevention. She also has responsibility for financial management, health policy and planning, and office systems and support services. The State Dental Director, Dr. Harry Goodman and Office of Oral Health report directly to Dr. Moy.

FHA oversees a diverse array of public health programs within eight offices and two chronic rehabilitative facilities. The target population includes Maryland's total population of 5.6 million people, covering the lifespan from pregnancy to adulthood. Within the total population, at risk and vulnerable populations including low income, uninsured and medically underserved populations are programmatically identified and safety net services are provided.

***An attachment is included in this section.***

## D. Other MCH Capacity

Maryland's MCH Program includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. This team plans, manages, and monitors Title V activities for Maryland from the Downtown Baltimore offices of Maryland's State Office Complex. In addition, MCH staff in local health departments, including a cadre of community health nurses, physicians, program administrators and clerical personnel, are also supported by Title V funds.

Center for Maternal and Child Health (CMCH)

CMCH currently has 38 full and part-time staff providing 36.1 FTEs. As noted on the attached organizational chart, CMCH is organized into four units. The largest of these, Perinatal and Reproductive Health, has 8 FTEs at the central office and 4.5 FTEs assigned in the field with direct clinical duties. The majority of the positions in this unit are federally funded by Title X. Maryland's commitment to workforce development is evidenced by the number of graduate student internships. Several CMCH staff have faculty appointments or serve as instructors in MPH programs at Johns Hopkins and University of Maryland.

CMCH is directed by Bonnie S. Birkel, CRNP, MPH. Ms. Birkel is a trained nurse practitioner with a Master of Public Health degree and over 25 years of experience in public health. She is responsible for MCH policy development and is the official spokesperson for all MCH and family planning related areas. She has served as CMCH's Director since its inception in 2000.

Dr. S. Lee Woods, a neonatologist with a Ph.D. in genetics, serves as Medical Director for CMCH. Dr. Woods oversees and provides medical consultation on clinical policy, quality improvement, and legislative issues. Dr. Woods serves as CMCH's primary liaison with the DHMH Office of Communication for public affairs, and also was recently appointed as Secretary Colmer's designee as Chair of the Morbidity, Mortality and Quality Review Committee.

Dr. Woods is supported by Cheryl DePinto, MD, MPH, Medical Director for Child and Adolescent Health, who is board certified in pediatrics and adolescent medicine and serves as Principal Investigator (PI) for the CDC Asthma cooperative agreement; Diana Cheng, MD, Medical Director for Women's Health who is a board certified obstetrician/gynecologist, and serves as the PI for the CDC PRAMS cooperative agreement; and Pamela S. Putman, RN, BSN, MPH who is the senior MCH Nurse-Consultant and serves as Chief of MCH Systems Improvement which includes oversight of the statewide Improved Pregnancy Outcome Program.

Yvette McEachern, M.A., serves as Director of Federal/State MCH Partnerships. Ms. McEachern serves as the Title V Administrator and SSDI Project Director in Maryland and oversees development of the Title V application including data collection, performance monitoring and needs assessment. Ms. McEachern has over 20 years experience as a health policy analyst, research statistician, and program administrator. Key staff in Ms. McEachern's unit include Mary LaCasse, Early Childhood Program Manager and Prevention Coordinator; Christine Evans, the Title V-designated Adolescent Health Coordinator and Teen Pregnancy Prevention Coordinator; Rachel Hess-Mutinda , Asthma Program Administrator, and Linda Nwachukwu, Asthma Epidemiologist.

Marsha Smith, MD, MPH, Director of Perinatal and Reproductive Health, oversees the federal Title X Family Planning Program, the Title X HIV Integration Project, and the Babies Born Healthy Initiative. She has responsibility for oversight of clinical services under the family planning program and supervises a staff of 12. Dr. Smith has been appointed as Secretary Colmer's designee for the State Child Fatality Review Team and oversees the Maternal Mortality Review Program. Dr. Smith is a board-certified pediatrician with previous public health experience as the Medical Director for the Baltimore City Health Dept. STD program, and as Acting Assistant Health Commissioner in Baltimore.

Lee Hurt, MS, MPH has served as the MCH Epidemiologist since 2007. She is a doctoral student at the George Washington University School of Public Health. Ms. Hurt is the CMCH's primary liaison for data with the Medicaid program, with other units within the Family Health Administration, other DHMH Administrations (including the Vital Statistics Administration), and Children's Cabinet agencies. Ms. Hurt also oversees the PRAMS program.

Office for Genetics and Children with Special Health Care Needs (OGCSHCN)

Susan R. Panny, M.D., oversees the work of the Office for Genetics and Children with Special Health Care Needs. Dr. Panny is certified in both Pediatrics and Medical Genetics. She has 32 years of experience in pediatrics and genetics and 26 years of experience in public health. She is an internationally known figure in newborn screening and public health genetics. She has served as the Director of the OGCSHCN since 2000, and prior to that had served as Director of the Office for Hereditary Disorders since 1984. Dr. Panny will be retiring at the end of the year. Meredith Pyle, BA, a graduate student from the Maryland Institute for Policy Analysis and Research at the University of Maryland, Baltimore County has held a Graduate Student

Assistantship with the OGCSHCN for 2 years and has been invaluable in working with OGCSHCN and PPMD on the State Systems Integration Implementation Grant, the Needs Assessment, the Block Grant Application and various policy issues. An additional physician, expert in issues relating to CYSHCN, is being recruited.

Donna X. Harris, BA, serves as Deputy Director of the Office for Genetics and Children with Special Health Care Needs and oversees all administrative issues. Ms Harris has 13 years of administrative experience within Family Health section of the Department of Health and Mental Hygiene, 10 years of it with the OGCSHCN. The Office Support group currently consists of a secretary, a grants /contracts/ procurement staff member and a data manager/It consultant. A chief fiscal officer is being recruited. Chevria Meekins has provided secretarial support to the Director and Deputy Director for 7 years and handles the corporate credit card and purchasing for the OGCSHCN. Sharon Burke has handled Procurement and Grants and Contracts for the OGCSHCN for 16 years and brings many years of experience in interacting with families from the Division of Child Support in the Department of Human Services. Ms Greer, from the CMS program, also handles personnel issues for the unit.

Erin D. Filippone, M.Ed., CCC-A, has served as a senior audiologist with the Infant Hearing Screening Program for 4 years and is currently serving as acting chief of that program. She has extensive previous experience as the audiologist in a pediatric ENT practice. The Infant Hearing Screening program is also staffed by 2 follow up coordinators and a secretary. Theresa Thompson, BA, MFA has served as a follow up coordinator for 7 years and brings experience in teaching and public health administration. Stephanie Hood, BA has served as a follow up coordinator for 3 years and brings experience in case management. Hope Wharton has provided secretarial support for 3 years and brings 9 years of experience with the State's chronic hospitals.

Mary Kalscheur, MS, RD, LD, serves as the chief of the Metabolic Disease Nutrition program. Ms Kalscheur has 15 years of experience in the field of metabolic disease nutrition and dietary therapy and 10 years of experience in oral motor therapy. A second metabolic disease nutritionist is being recruited.

Patricia Williamson, BSN, RN has served as the chief of the Children's Medical Services program for 6 years. She oversees medical eligibility for the program and reviews and preauthorized all services provided through CMS. Her previous experience with the medical assistance program has been very valuable in assisting eligible families to apply for medical assistance or other programs that may provide broader coverage than CMS. Ms Williamson is ably assisted by an administrative specialist and a secretary. Barbara L. Greer, has handled financial eligibility for the CMS program for 21 years and manages the toll free Children's Resource Line. Ms Greer brings experience in working with special needs populations from her years at Rosewoood. Joanne Johnson has handled the billing for the CMS program expertly for 20 years. Maquel Wilkes has provided secretarial support for the program for 2 years and has previous State secretarial and administrative experience in the correctional system.

Javier Figueroa-Ray, BA, MA, has served for 3 years as the bilingual Outreach Coordinator for Montgomery and Prince Georges Counties, assisting eligible families to apply for CMS and assisting with the case management for Spanish speaking families. His background in social work and community organization is extremely valuable to the program. He also assists eligible families to apply for primary care through the Primary Care Coalition. An additional staff member in Specialty Care and Regional Resource Development is being recruited. (The previous incumbent in that position was also bilingual in Spanish/English.)

Francis Sammanasu, with an Indian degree in Mechanical Engineering, is the newly hired Data Manager for the Birth Defects program and also serves as the information technology consultant for the entire OGCSHCN. His experience as an Oracle Data Base Administrator, originally gained in the semi conductor industry, and as an IT consultant has been extremely valuable. A nurse to head Birth Defects Program is being recruited.

Adi Bello, BSN, RN has served as the sickle cell disease nurse for 11 years, providing education and case management for children identified with sickle cell disease from birth to their 6th birthday. Ms Bello speaks several African languages which is extremely useful in serving Maryland's increasing African immigrant population. Her previous experience in the medical insurance industry and medical assistance program is very helpful. She is assisted by Marcia Diggs who has expertly handled all aspects of the sickle cell disease program that do not require nursing skills for over 14 years. Ms Diggs has many years of administrative experience in a variety of mid size corporations and brings expertise in the interpretation of lab results gained in her previous position with Maryland Medical Labs.

The OGCSHCN is very short staffed at the moment with most staff members handling multiple functions. However, the unit still has a very diverse staff, with Hispanic, Indian, African and African- American as well as Caucasian staff members. The OGCSHCN has staff members who are bilingual in Spanish, and fluent in several African languages, Hindi, several regional Indian languages, German and French (including Haitian). Several staff members have children with special needs. These staff members were hired for their professional expertise and not solely to provide parent input but do provide parent input and give permission for their specific areas of interest to be mentioned. One provides a parent's perspective on transition as she has a grown daughter with Down syndrome, another has a child with severe GI issues and one has a child with cancer. Several recently vacated staff positions were held by people with children with other special needs (neural tube defects and severe neurological impairment). The OGCSHCN is fortunate in that our close relation ship with PPMD also provides parent input.

## E. State Agency Coordination

Center for Maternal and Child Health

As noted in Section C, the Governor's Office for Children (GOC) is the coordinating unit for the Children's Cabinet. CMCH has been invited to brief the Children's Cabinet on a number of important MCH issues including: FASD, teen pregnancy, infant mortality, and most recently, home visiting. GOC is a partner in the Governor's Infant Mortality Initiative, and has agreed to serve in an advisory and decision-making role for the new federal home visiting program which will be administered by CMCH. CMCH represents DHMH at annual briefings by GOC to the Maryland General Assembly Joint Committee on Children, Youth and Families. CMCH also works directly with the Children's Cabinet agencies in a number of programmatic areas. CMCH shares responsibility for school health with the Maryland Department of Education, provides consultation and technical assistance on adolescent health and teen pregnancy prevention to the Department of Juvenile Services, and collaborates with the Department of Human Resources on child abuse and neglect, teen pregnancy prevention, outreach for family planning, and early initiation of prenatal care. At the local level, GOC funds Local Management Boards (LMBs) in every jurisdiction. The LMBs are comprised of the local agency counterparts to the Children's Cabinet agencies. The GOC has provided CMCH with the most recent needs assessments completed by LMBs for the MCH Home Visiting Needs Assessment.

CMCH works very closely with the Maryland Department of the Environment (MDE) and the Department of Housing and Community Development (DHCD) on childhood lead poisoning prevention. CMCH represents the Title V program on the Governor's Lead Commission; Medicaid is also represented on the Commission. In FY 2010, CMCH began collaborating with the Maryland Community Health Resources Commission to establish infant mortality reduction as a priority for Commission grants to safety net providers (primarily FQHCs). CMCH provides technical assistance for review of proposals, and has joined in site visits to grantees with Commission staff.

CMCH plays a major leadership and coordination role within the Family Health Administration and

partners with the Maryland WIC program (preconception health, family planning outreach, breastfeeding promotion), the Center for Health Promotion (smoking cessation, injury prevention, intimate partner violence), the Office of Chronic Disease Prevention (women's health, childhood obesity), the Center for Cancer Surveillance and Control (cervical cancer screening), and the Office of Oral Health (child health, perinatal health). Within DHMH, intra-agency partners include the behavioral health programs: the Mental Hygiene Administration (early childhood mental health, youth suicide, and perinatal depression) and the Alcohol and Drug Abuse Administration (perinatal substance abuse, Fetal Alcohol Spectrum Disorders), the Vital Statistics Administration (surveillance), the Office of the Chief Medical Examiner (child fatality, maternal mortality) and the newly formed Infectious Disease and Environmental Health Administration (STIs, immunization, asthma, lead poisoning, and the Children's Environmental Health and Protection Advisory Council). CMCH's collaboration with the DHMH Office of Minority Health and Health Disparities (OMHDD) has already been discussed earlier in the narrative. OMHDD is the primary resource for assuring cultural competency among DHMH and local health department staff. CMCH is frequently a training partner with OMHDD and has representation on the OMHDD Maryland Health Professional Education Committee.

CMCH is represented on the Maryland State School Health Council; the School--Based Health Advisory Council; the Partnership for a Safer Maryland (Injury Prevention); the Maryland Immunization Partnership Committee; the State Early Childhood Advisory Council; the Early Childhood Mental Health Steering Committee; the Maryland Developmental Disabilities Council; the Maryland Caregiver Support Coordinating Council; the Early Head Start Policy Council; the Latino Community Health Care Access Coalition; and the Maryland Suicide Prevention Commission. CMCH is also represented on the National Association of FASD State Coordinators.

Office for Genetics and Children with Special Health Care Needs (OGCSHCN)

Within DHMH, OGCSHCN has had a close collaboration with the Laboratories Administration (Labs) from the early 1960s and the development of newborn screening. The OGCSHCN and the Labs began AFP screening in 1981 serving a largely low income population. With the Medicaid expansions and the resulting decline in uninsured pregnant women, testing volume became too low to justify the State AFP lab and the OGCSHCN provided a partial subsidy to the AFP/Multiple Marker screen lab at University of Maryland Medical Center to serve the remaining patients. The OGCSHCN has also worked with the Labs and the DHMH Office for Health Care Quality on standards for laboratories performing tests for rare diseases.

Within FHA, OGCSHCN has provided data to the Office of Oral Health for its "burden document" and has included questions on oral health in the survey of families conducted through parents as part of this needs assessment. Plans to develop a system of oral health services for CSHCN is still a future goal.

OGCSHCN partners with the academic tertiary care centers by providing a partial subsidy for their specialty clinics and their genetics clinics. Genetics and pediatric specialty clinics rarely break even and the State grants offset their losses. In return, the centers provide care for CSHCN in their own institutions, within their referral networks and through a series of outreach clinics to bring these specialized services to outlying parts of the State. Local health departments and sometimes local community hospitals host these outreach clinics. OGCSHCN hopes to expand the outreach clinic network via telemedicine. In particular, Children's National Medical Center is exploring expanding the frequency of outreach clinics at six sites in central and southern Maryland. Primary partners are Johns Hopkins Medical Institutions (JHMI) including the Kennedy-Krieger Institute, the University of Maryland Medical Center (UMMC) and Children's National Medical Center (CNMC). Other partners include Sinai Hospital of Baltimore, Georgetown University Hospital, Howard University Hospital and George Washington University Hospital. Partnerships with centers in Washington, DC have been very strong since the early 1980s and CNMC receives OGCSHCN funding in the same way that JHMI and UMMC do. OGCSHCN has a

longstanding partnership with the West Virginia University Medical System, particularly in genetics, where Maryland and West Virginia cooperate in the scheduling of their outreach clinics in border areas to provide maximal service to the local population. Generally speaking, each of these states will accept MA from either state, although it can be more complex when MCOs are involved. The major problem encountered in cross state academic and health agency partnerships is the difficulty in exchanging protected health information when referring patients or following up on referrals. States have their own statutes and regulations requiring information sharing between practitioners and agencies serving the same patient, especially in newborn screening, but these do not apply in neighboring jurisdictions. The OGCSHCN is also a frequent partner in the research efforts of the academic medical centers, especially those involving new born screening, birth defects, and gene frequencies.

The OGCSHCN was instrumental in the establishment of the Maryland Alliance of PKU Families (MAPKUF), the Maryland Sickle Cell Disease(SCD) Association and a number of local chapters of national or international groups such as NF, Inc- Mid Atlantic and the regional SOFT (Support Organization for Trisomy) chapter. OGCSHCN works closely with the parent and patient groups supported by the local academic institutions, such as the pediatric SCD support groups at JHMI and CNMC, the adult SCD group and Destiny Despite Diagnosis at JHMI. The OGCSHCN also works with the established local chapters of national organizations, such as the Chesapeake-Potomac Spina Bifida Association, various Down syndrome groups, the Maryland Society for Cleft lip and Palate Children, the Maryland Hemophilia Foundation, the Cooley's Anemia Association, the Maryland Society for Sight, the Maryland Association of the Deaf, FACES (craniofacial disorders), the MSUD Family Support Group, Parents of Galactosemic Children, the Fatty Acid Oxidation Disorders Family Support Group (FOD), the Organic Acidemia Association (OAA), the Cystic Fibrosis Foundation, the CARES Foundation (congenital adrenal hyperplasia), and many more. The OGCSHCN participates in many educational programs with voluntary groups. The OGCSHCN sponsors specialty summer camps in partnership with MAPKUF (PKU), NF Inc-Mid--Atlantic (NF), Diagnosis Despite Destiny (for SCD) and sometimes the Chesapeake Potomac Spina Bifida Association as a way of providing respite care and disorder specific health education. The OGCSHCN sponsors pre-school vision screening in partnership with the Maryland Society for Sight.

OGCSHN staff the Advisory Council on Hereditary and Congenital Disorders, which has set the principles and standards for all genetic programs in Maryland since 1973, promoting partnership between the DHMH, the academic tertiary care centers, professional organizations, consumers and the legislature around issues in genetics.
The OGCSHCN was involved in the early efforts to establish an umbrella genetic disorders advocacy group that evolved into the Genetic Alliance and participates in selected Genetic Alliance activities.

The OGCSHCN has a very close partnership with Parents' Place of Maryland (PPMD), the Maryland Family Voices chapter. PPMD is a broad umbrella organization advocating for families of CSHCN. OGCHCN also has representation on numerous interagency councils, task forces, and committees. These include various committees of the Maryland Chapter of the American Academy of Pediatrics, the Advisory Council for Hereditary and Congenital Disorders, the Advisory Council for Hearing Impaired Infants, the Advisory Board of Cooley's Anemia Foundation of Maryland, the Maryland Sickle Cell Disease Association, the Traumatic Brain Injury Advisory Council, the Developmental Disabilities Care Givers Support Coordinating Council, Neurofibromatosis Inc.-Mid Atlantic, the Maryland Alliance of PKU Families, and the Maryland Hemophilia Foundation. The private sector includes an array of birthing hospitals and centers as well as office-based obstetrical, pediatric, and primary care providers, managed care organizations, federally qualified health centers, and rural health networks. Specialty care needs are addressed through a network of community-based providers, tertiary care centers ("Centers of Excellence"), a genetics network, and linkages with the Shriner's Hospital through the MCHB sponsored Choices Program.

Coordination with Medicaid

Both CMCH and OGCSHCN have at least quarterly coordination meetings with key staff in Medicaid. An updated Title V/Title XIX/Title X/WIC cooperative agreement between the Family Health Administration and Medicaid is in the final approval process and will be available for federal review prior to the August meeting with MCHB for the Maryland Title V Block Grant. The seventeen page document contains eight sections: administration and policy; reimbursement and contract monitoring; data exchange; outreach and referral activities; training and technical assistance; provider capacity; system coordination; and quality assurance. Each of these sections is further organized into sections for primary preventive services and oral health; pregnant women and infants; children with special health care, and family planning. CMCH also has established a formal MOA with Medicaid for collaboration and cost-sharing for the Medicaid Prenatal Risk Assessment which is used by prenatal providers statewide. CMCH and Medicaid recently collaborated on a special project with University of Maryland College Park to develop outreach strategies to increase utilization of family planning and early initiation of prenatal care in Prince George's Co. As previously noted, Medicaid is partner in the Governors infant mortality initiative.

## F. Health Systems Capacity Indicators

**Introduction**

Health capacity indicator data is collected from several sources including Vital Statistics, the Injury and Sexually Transmitted Infections surveillance systems, and State program databases. These data are used to monitor capacity needs that may have either a negative or positive effect on the health of Maryland children. The data are distributed to MCH staff at the State and local levels to assist with program planning and policy development.

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Indicator | 34.2 | 35.4 | 37.7 | 38.0 | 38.0 |
| Numerator | 1303 | 1303 | 1409 | 1412 | 1412 |
| Denominator | 381487 | 368199 | 374133 | 371787 | 371787 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**

Data Source: HSCRC, 2008

**Notes - 2007**

Source: HSCRC Hospital data and ambulator data, NCHS Vintage 2007 Population File.

**Narrative:**

The State's ability to address asthma from a public health perspective has been influenced by legislation mandating creation of a State Asthma Control Program and CDC funding to support asthma control activities. The Maryland Asthma Control Program (MACP) addresses both pediatric and adult asthma and is administratively housed in CMCH. The Maryland Legislature

mandated establishment of the MACP in 2002 and charged the Program to develop a statewide asthma surveillance system and an asthma control program. Maryland has received a CDC asthma grant since 2001 that supports staff salaries (i.e., an asthma epidemiologist, administrator and evalutor) and funds sub-grantees. Title V partially supports the costs of administrative staff, program printing and the purchase of educational materials.

Since 2002, with the assistance of a CDC Asthma control grant, the Program has developed and revised an asthma plan (with support from Asthma Coalition members), built a surveillance system, and implemented initiatives in an effort to address Program goals. Asthma Control Program funding is supplemented by the Maternal and Child Health Block Grant.

Surveillance is the cornerstone of the Maryland Asthma Control Program. Analysis includes prevalence, emergency department visit rates, hospitalization rates, mortality rates, health disparity assessment, asthma-related health behaviors, and asthma-related health care costs. To date, seven annual asthma surveillance reports have been completed for the years 2002-2008. The 2008 Maryland Asthma Surveillance Report (most recent report available) indicates that statewide, an estimated 190,000 children have been diagnosed with asthma at some point in their lifetime. This represents 13.6% of children. An estimated 123,000 children (8.9%) currently have asthma. Children under the age of 5 had the highest hospitalization rate of any age group at 42.1 hospitalizations per 10,000 population in 2007. Maryland's rate was higher than the national average in 2006. Hospitalization rates for all age groups continued to exceed Healthy People 2010 goal of 25 hospitalizations per 10,000. Hospitalization rates for African Americans in 2005 were three times that of Whites. The emergency department visit rate was four times higher for African Americans as compared to Caucasian Americans.

Maryland's SSDI Project Team works collaboratively with the State's asthma surveillance team to complete annual asthma surveillance reports and issue briefs. The surveillance team regularly analyzes the BRFSS and other datasets to assist in addressing racial and ethnic disparities. Medicaid data is also to analyze specific population needs.

Throughout 2009 and 2010, MACP has worked diligently with the Maryland Department of Education, local departments of education and local health departments to implement the Asthma Friendly Schools program. Thus far, over 25 schools have been designated as an Asthma Friendly School, with over 10 more applications pending.

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 85.9 | 86.0 | 87.9 | 84.1 | 84.8 |
| Numerator | 28799 | 30488 | 32206 | 31844 | 31270 |
| Denominator | 33517 | 35450 | 36639 | 37842 | 36864 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

**Notes - 2008**
Source: Medicaid data for Federal Fiscal Year 2008

**Notes - 2007**
Source: Maryland Medicaid Program. Defined as those born between 1/1/7 - 9/30/07. Initial periodic screen defined as CPT code 99381; 99391; 99341 or diagnosis codes starting with v20.2; v77.0; v77.9; v78.0-v78.9.

**Narrative:**
Data for this indicator is provided by the Medicaid Program. Increasing percentages of infants enrolled in Medicaid are receiving at least one periodic screen. In Federal Fiscal Year 2007, 88% of the 36639 infants enrolled received a screen; up from 75% in FFY 1999.

Maryland's EPSDT Program is known as the Healthy Kids Program. The Program's goal is to promote preventive health care services for children to promote early identification and treatment of health problems before they become medically complex and costly to treat. Standards for the Healthy Kids Program are developed in collaboration with the Title V Agency and other key MCH stakeholders such as the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School, and the Maryland Department of the Environment. The "Maryland Schedule of Preventive Schedule of Preventive Health Care" closely correlates to the American Academy of Pediatrics' periodicity schedule. Most infants are enrolled in HealthChoice, Medicaid's managed care program which began in 1997. Medicaid recipients enroll in a managed care organization of their choice and select a primary care provider to oversee their medical care. The HealthChoice Evaluation data for 2006 indicates that the percentage of infants (includes those enrolled in both traditional Medicaid and MCHP) receiving a well child visits increased between 2000 and 2003, from 69.2% to 79.4%. Well child visits were defined by Medicaid to include well child visits, EPSDT and preventive services.

In CY 2009 84.8% of the 36,864 infants (less than 1 year of age) received at least one initial periodic screen, up from 84.1% in 2008. Maryland Medicaid uses HEDIS measures to report well-child visits. The percentage of 15-month-old infants (Medicaid and MCHP) who received at least five well-child visits with a PCP increased from 81% in CY 2004 to 83% in CY 2008. The National HEDIS Medicaid average for CY 2008 was 75%.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 73.3 | 52.6 | 83.9 | 85.3 | 83.8 |
| Numerator | 211 | 201 | 433 | 1119 | 804 |
| Denominator | 288 | 382 | 516 | 1312 | 960 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

**Notes - 2008**
Source: Medicaid data for Federal Fiscal Year 2008.

**Notes - 2007**
Source: Maryland Medicaid program data for FFY 2007. Infants defined as those born between 10/1/07 to 9/30/07.

**Narrative:**
Maryland's CHIP Program is known as the Maryland Children's Health Program (MCHP). MCHP provides full Medicaid health benefits to children up to age 19, who meet the income guidelines. Children in families with incomes above the qualifying income for Medicaid but below 200% of FPL are eligible for free coverage. Families with incomes between 200 and 300% of poverty pay a small monthly premium. Children enrolled in MCHP are required to participate in the Maryland Health Choice Program and must join a Managed Care Organization (MCO).

In CY 2009 83.8% of the 960 infants (less than 1 year of age) enrolled in MCHP received at least one initial periodic screen, up from 85.3% in 2008. Maryland Medicaid uses HEDIS measures to report well-child visits. The percentage of 15-month-old infants (Medicaid and MCHP) who received at least five well-child visits with a PCP increased from 81% in CY 2004 to 83% in CY 2008. The National HEDIS Medicaid average for CY 2008 was 75%.

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 70.1 | 69.4 | 69.7 | 71.5 | 71.5 |
| Numerator | 52491 | 53712 | 54389 | 55249 | 55249 |
| Denominator | 74880 | 77430 | 78057 | 77268 | 77268 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Data for 2009 not available. Derived from 2008 Vital Statistics Administration data.

**Notes - 2008**
Derived from Vital Statistics Administration data, 2008.

**Notes - 2007**
Derived from Vital Statistics Administration Data, 2007.

**Narrative:**
Maryland has monitored this indicator since 2000. There has been little change over these years with approximately 70% of Maryland women receiving adequate prenatal care, according to the Kotelchuck Index. There have been a small improvement in each of the last 2 years, with 2008 data (71.5%) showing a 3% improvement from the low of 69.4% reported in 2006. Adequate prenatal care varies by race and ethnicity, from 79.1% for Asian women, 73.6% for white women, 66.4% for Black women, and 58.4% of Hispanic women. Medicaid status is also a factor, with 78.3% of non-Medicaid women receiving adequate prenatal care compared with 62.3% of women on Medicaid. Early prenatal care in Maryland has been declining since the late 1990s, with Maryland falling below the national average since 2003. In 2008, the percentage of Maryland women accessing early prenatal care increased slightly to 80.2%.

In FY 2010, Babies Born Healthy Initiative programs continued to focus on prevention services, quality improvement, and data systems development. A state-of the-art web-based electronic birth certificate was implemented in January 2010, and will allow timelier and more complete reporting of data, including the timing of prenatal care. The MCH program continues to strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a partnership (the MD Advanced Perinatal Support Services [MAPSS]) with the State's two academic medical institutions. In FY 2009, CMCH completed regulations for House Bill 535, passed by the MD Legislature in 2008. The regulations codify the State's FIMR Program, and establish a Morbidity, Mortality and Quality Review Committee which will review statewide outcomes related to pregnancy, childbirth, infancy and early childhood. The initial meeting of the Committee will be in June 2010.

The new Governor's Delivery Unit (GDU) Plan addresses the Governor's strategic goal to reduce infant mortality in Maryland by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. Programs and strategies focus on the three critical periods before, during, and following pregnancy. One specific goal is earlier entry into prenatal care. Maryland Medicaid has implemented an Accelerated Certification of Eligibility (ACE) process, providing coverage for pregnant women beginning within 48 hours of an abbreviated application process and continuing up to 90 days while a full Medicaid application is completed. The three target local health departments are implementing "Quickstart" prenatal care services, with expanded screening and referral services, and deployment of community outreach workers.

## Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 79.5 | 80.7 | 83.6 | 83.8 | 87.1 |
| Numerator | 321369 | 324114 | 317571 | 333454 | 367410 |
| Denominator | 404286 | 401816 | 379937 | 397848 | 421616 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note: Data is for Children Age 1-20 Years receiving a service paid by the Medicaid Program.

**Notes - 2008**
Source: Medicaid data for Federal Fiscal Year 2008.

**Notes - 2007**
Source: Medicaid data for Federal Fiscal Year 2007.

**Narrative:**
Medicaid provides health care coverage for Maryland's poorest and most vulnerable children. Maryland has generous eligibility standards; children in families with incomes up to 300% of the federal poverty level (FPL) are eligible for full Medicaid benefits. During CY 2009, more than 339,315 eligible children and teens ages 0-19 were enrolled in Medicaid. This included children enrolled in the State's CHIP program, which is also administered by the Maryland Medicaid Program. Children up to age 19 in families with incomes between 200-300% FPL must pay a monthly premium (~2% of income). The premium is per family per month, regardless of the number of children covered.

The majority of Medicaid and CHIP enrolled children are required to participate in HealthChoice, Maryland's statewide mandatory managed care program. Recipients enroll in a managed care organization ( MCO) of their choice and select a primary care provider to oversee their medical care. All children under age 21 are entitled to comprehensive services including EPSDT and dental services. The majority of services are part of the MCO benefit package. Some specialty services such as OT, PT, and speech therapies are paid directly to the provider by the Medicaid program. As of 7/1/2009, dental services are no longer paid by the MCO. Medicaid now contracts with an ASO to administer the Maryland Healthy Smiles Program.

## Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 48.7 | 51.6 | 46.7 | 50.7 | 58.8 |
| Numerator | 28071 | 32065 | 44600 | 52569 | 64594 |
| Denominator | 57589 | 62166 | 95464 | 103645 | 109845 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

**Notes - 2008**
Source: Medicaid data for Federal Fiscal Year 2008.

**Notes - 2007**
Source: Maryland Medicaid Program, calendar year 2007. Age as of 1/1/07.

**Narrative:**
EPSDT mandates that children under than 21 have dental benefits and access to comprehensive oral health care. Maryland's dental utilization rate has been historically low. Before Maryland implemented the HealthChoice Medicaid managed care program in 1997, only 14 percent of Maryland children enrolled in Medicaid for any period of time received at least one dental service, below the national average of 21 percent.
From 1997 through June 2009, Medicaid children received dental services through their MCO. Maryland used a modified HEDIS measure (number of children 4-20 who were enrolled at least 320 days) to assess the performance of the MCOs. Under managed care, Maryland's utilization of dental services improved significantly; the rates increased 180 percent from 19.9 percent in 1997 to 55.7 percent in 2008.

In June 2007, in an effort to further increase access to oral health care and service utilization, a Dental Action Committee (DAC), was convened. The DAC was comprised of a broad-based group of stakeholders concerned about children's access to oral health services. Key recommendations from the report included increased reimbursement for Medicaid dental services and the institution of a single dental ASO. The reforms recommended by the DAC have been supported and, to a great degree, instituted by DHMH to effectively address the barriers to dental care access previously experienced in the State. Dental provider rates were increased in 2008, and DHMH is committed to a second round of rate increases once the budget situation improves. Based on the recommendation of the DAC, effective July 1, 2009, all dental services for all Medicaid children are now provided through the state's contracted ASO, DentaQuest, which administers the Maryland Healthy Smiles program. Since the ASO began administering the program the number of participating dental providers has increased. DentaQuest is also performing outreach and education to parents to increase the number of children who receive routine preventive care as well as follow up for any needed restorative care.

Expanded access to dental care also has been achieved through initiatives of the Office of Oral Health. As of July 1, 2009, Medicaid began reimbursing EPSDT-certified medical providers (pediatricians, family physicians, and nurse practitioners) for fluoride varnish treatment and oral assessment services provided to children between 9 and 36 months of age. The providers must first complete an Office of Oral Health training program.
MCH continues to work closely with Medicaid and the Maryland Dental Action Coalition to make access to dental care and ultimately a dental home a reality for all Maryland children.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 0 | 0 | 0 |
| Denominator | 14720 | 15275 | 13246 | 13575 | 13856 |
| Check this box if you cannot report the numerator because | | | Yes | Yes | Yes |

| | | | | | |
|---|---|---|---|---|---|
| 1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
This annual indicator is zero. The OGCSHCN is currently only able to track this data in the Children's Medical Services Program. The average number of SSI recipients receiving rehabilitative services from the CSHCN program has been less than 5 for many years. (It is actually 3 for FY 2009.) Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2009 ( Social Security Administration.) obtained from the Health and Ready to work web-site.

**Notes - 2008**
This annual indicator is in fact zero. The Children's Medical Services Program (CMS) does not pay for care for SSI/ MA eligible children if the needed service is covered by Medicaid.

CMS will pay for needed specialty care services that are not provided by Medicaid.

The OGCSHCN is currently only able to track this data in the Children's Medical Services Program (CMS) and only two SSI benficiaries less than 16 years of age are on the CMS eligibility list , both received services from CMS in 2007 but neither received services from CMS in 2008. Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2008 from the Social Security Administration.

**Notes - 2007**
This annual indicator is zero. The OGCSHCN is currently only able to track this data in the Children's Medical Services Program, and only two SSI benficiaries less than 16 years of age received services from this program in 2007. Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2007 from the Social Security Administration.

**Narrative:**
HSCI#8

The OGCSHCN is currently only able to track this data in the Children's Medical Services Program (CMS). The average number of SSI recipients receiving rehabilitative services from the CSHCN program has been less than 5 for many years. (It is actually 3 for FY 2009.) Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2009 ( Social Security Administration) obtained from the Health and Ready to work web-site.

This HSCI, as far as the CMS data can be interpreted, had already been met.

## Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of low birth weight | 2008 | payment source | 11.1 | 8.2 | 9.3 |

| | | | | | |
|---|---|---|---|---|---|
| (< 2,500 grams) | | from birth certificate | | | |

**Narrative:**
Prematurity and low-birth weight are the leading causes of infant deaths in Maryland. Risk factors for prematurity or low birth weight include medical conditions and complications as well as behavioral/social factors such as maternal smoking, maternal weight gain and late entry into prenatal care. In 2008, 89% of very low birth weight infants born in Maryland were delivered at high-risk facilities.

In 2008, over 9% of all Maryland babies were born at low birth weights (less than 2,500 grams). Maryland has much work to do to reach the Healthy People 2010 goals for low birth weight (5%) and very low birth weight (0.9%).

Maryland's low birth weight rate has consistently been higher than the national average (9.3% for MD in 2008 and 8.2% for U.S. in 2007). The percentage of infants born at low birth weight in Maryland fluctuated over the last 10 years, from a low of 8.7% in 2000 to highs in 2004 and 2006 of 9.4%.

The low birth weight rates for Blacks in 2008 were substantially higher than that of other racial and ethnic groups. Black babies (13.2%) were more likely than Asian (8.1%), White (7.2%), and Hispanic (7.1%) babies to be born at low birth weights. Six jurisdictions had low birth weight rates considerably above the statewide average of 9.3% in 2008: Baltimore City (12.8%), Dorchester (12.2%), Somerset (10.8%), Garrett (10.8%), Prince George's (10.6%), and Allegany (10.3%) counties.

The Title V Agency works with local health departments, the March of Dimes, state medical associations, advocacy groups, hospitals and community based organizations to improve women's preconception health and reduce adverse birth outcomes such as low birth weight.

### Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Infant deaths per 1,000 live births | 2008 | matching data files | 8.7 | 7.3 | 7.8 |

**Narrative:**
Data for this indicator is derived from linked birth and infant death records for 2008. As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly more likely to have a baby die within the first year of life.

Strategies include MCH-WIC Collaborative Projects in Baltimore City, and Baltimore, Charles, and Wicomico Counties where MCH services (including family planning, folic acid distribution, and others) are linked with WIC services to maximize women's health during the preconception and interconception period, which is key to positive birth outcomes. Another strategy is the Maryland Advanced Perinatal System Support (MAPSS) Project. This University of Maryland Program provides telemedicine linkages between high-risk obstetrical consultants and local providers and three hospitals. This is necessary because there is a shortage of obstetrical providers throughout the State, and MAPSS supports local providers, which enables them to stay

in practice.

Patient safety has become a national priority as a result of the groundbreaking Institute of Medicine Report entitled "To Err is Human." Some infant deaths in Maryland are attributable to patient safety concerns. In partnership with the Maryland Patient Safety Center's (MPSC), the Perinatal Collaborative is bringing together 25 Maryland hospitals to advance patient safety. Hospitals are improving communication, enhancing education, and establishing safety-related protocols. All 25 hospitals are submitting data into a single database at the National Perinatal Information Center. This phase of the collaborative will end with a results congress in May. We have already begun discussing continuation of the collaborative with a focus on NICUs for FY 2011.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2008 | payment source from birth certificate | 68.5 | 88.6 | 80.2 |

**Narrative:**
Data for this indicator is derived from birth records for 2008. As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly less likely to receive early prenatal care. Early prenatal care rates have continued to decline for both Medicaid and non-Medicaid women over the past decade. National performance measure #18 discusses state activities directed at improving this situation.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) | 2008 | payment source from birth certificate | 62.3 | 78.3 | 71.5 |

**Narrative:**

Maryland recently began to analyze the data to be able to monitor progress on this indicator. The data show that less than 72% of Maryland moms are receving adequate prenatal care according to the Kotelchuck Index. Early prenatal care in Maryland have been declining for the past several years which is a cause of concern for the Title V Program. This year through both the Title V needs assessment and the new Babies Born Healthy Initiative, the MCH Program plans to explore in depth the slide in prenatal care rates and to develop an action agenda that includes both community based and institutional level strategies to address the problem. CMCH plans to hire a new MCH epidemiologist to aid in spearheading this effort.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Infants (0 to 1) | 2009 | 185 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Infants (0 to 1) | 2009 | 300 |

**Notes - 2011**
Source: Maryland Medicaid, 2009

**Notes - 2011**
Source: Maryland Medicaid, 2009
185-300% covered by MCHP, MA covers up to 185% FPL.

**Narrative:**
Maryland Medicaid covers infants in families with incomes up to and including 185% of the Federal Poverty Level. The MCHP program covers infants in families with incomes between 185 and 300% of the poverty level.

CMCH supports and participates in many programs to address the needs of this age group. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in 2008. High-risk obstetric services are provided by the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. The Office for Genetics and Children with Special Health Care Needs also supports programs for children with metabolic diseases, hemoglobinopathies and birth defects.
Other programs include the MD Asthma Control Program; MD Asthma Coalition; Teen Pregnancy Prevention; Lead Poisoning Prevention Commission; Fetal Alcohol Spectrum Disorders Coalition; Fetal and Infant Mortality Review; Child Fatality Review; Maternal Mortality Review; and a legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood that will convene in early FY 2010.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

| **INDICATOR #06** | **YEAR** | **PERCENT OF** |
|---|---|---|

| **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | | **POVERTY LEVEL Medicaid** |
|---|---|---|
| Medicaid Children<br>(Age range 1 to 6)<br>(Age range 6 to 18)<br>(Age range to ) | 2009 | <br>133<br>116 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Medicaid Children<br>(Age range 1 to 18)<br>(Age range to )<br>(Age range to ) | 2009 | <br>300 |

**Notes - 2011**
Source: Maryland Medicaid, 2009

**Notes - 2011**
Source: Maryland Medicaid, 2009
MCHP: Children 1-6: 133-300%, MA covers up to 133% FPL
MCHP: Children 6-18: 116-300%, MA covers up to 116% FPL

**Narrative:**
Medicaid eligibility coverage for young children extends to families with incomes up to 133% of the federal poverty level (FPL). Coverage for older children extends to families with incomes up to 116% of the poverty level. Maryland's MCHP Program extends coverage for children in families with incomes up to 300% of the poverty level.

Maryland's MCHP Program is one the richest in the nation in terms of the types of services covered as well as income eligibility. Assets are not considered in determining eligibility. It is a Medicaid expansion program and CHIP children receive the same benefits as children who are eligible for Medicaid.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Pregnant Women | 2009 | 250 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Pregnant Women | 2009 | |

**Notes - 2011**
Source: Maryland Medicaid, 2009

**Notes - 2011**
In Maryland, pregnant women are not covered by MCHP; pregnant women up to 250% of FPL are Medicaid eligible.

**Narrative:**
Maryland Medicaid provides coverage for pregnant women with income levels up to 250% of the Federal Poverty level. In Maryland, pregnant women are not covered by MCHP. In 2009, there were 28,219 pregnant women enrolled in Medicaid.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| **DATABASES OR SURVEYS** | **Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)** | **Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)** |
|---|---|---|
| ANNUAL DATA LINKAGES<br>Annual linkage of infant birth and infant death certificates | 3 | Yes |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | 2 | No |
| Annual linkage of birth certificates and WIC eligibility files | 1 | No |
| Annual linkage of birth certificates and newborn screening files | 3 | No |
| REGISTRIES AND SURVEYS<br>Hospital discharge survey for at least 90% of in-State discharges | 3 | Yes |
| Annual birth defects surveillance system | 3 | Yes |
| Survey of recent mothers at least every two years (like PRAMS) | 3 | Yes |

**Notes - 2011**

**Narrative:**
The MCH Program has access to timely population based and program data from several sources. Maryland has established and is working on improving routine access to four of the eight linked data sets and surveys identified in Title V Block Grant Health Systems Capacity Indicators #9(A) and (B): 1) the annual linked birth-death certificate database, 2) a linked birth and newborn screening file; 3) birth defects surveillance system, 4) the hospital discharge database, 5) the Pregnancy Risk Assessment Monitoring System (PRAMS), 6) the Youth Risk Behavior Surveillance System (YRBS), 7) linked birth and Medicaid files, and 8) linked birth and WIC files. Analyses and reports generated from these databases have been used to conduct surveillance, develop MCH reports and enhance MCH program and policy development. In addition, the MCH

Program has been working with Medicaid to gain direct access to a Medicaid database, on an as-needed basis. This connection is being utilized to link Healthy Kids data with information from the Medicaid managed care enrollee database for a study on childhood obesity.

Maryland became a PRAMS state in 1999 and released its first PRAMS Report covering 2001 births in April 2004. PRAMS reports for the 2002-2005 birth cohorts have been completed. PRAMS data will be used to track and monitor several state and national performance measures including unintended pregnancy and breastfeeding; and to conduct in-depth analyses to guide planning for perinatal systems building.

Since the mid-1990's, Maryland's SSDI Project has focused on improving epidemiologic and data capacity at the State level; strengthening the State's ability to assess annual targets for Title V performance measures; and improving State and local capacity to assess and prioritize needs, develop annual plans, and monitor program performance.

Maryland continues to negotiate with WIC and the Vital Statistics Administration to obtain electronic access to files relevant to MCH data analysis and needs assessment.

The Title V progress has direct access linked infant birth and death certificates.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| DATA SOURCES | Does your state participate in the YRBS survey? (Select 1 - 3) | Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N) |
|---|---|---|
| Youth Risk Behavior Survey (YRBS) | 3 | No |

**Notes - 2011**

**Narrative:**
Maryland used funds received from the tobacco settlement to establish the legislatively mandated Tobacco Use Prevention and Cessation Program. The Program was required to collect baseline data on tobacco use habits among youth (middle and high school students) and adults at the state and local levels. These surveys were to be repeated at least every other year for use in monitoring achievement of program goals. Baseline data for the Maryland Youth Tobacco Survey was collected in the fall of 2000. A second survey was completed in the fall of 2002. A third survey was completed in 2006. The results of the three surveys were summarized in a 2007 report, which clearly showed a steady decline in the rate of smoking initiation among underage youth across this time period. The surveys show that tobacco use by youth attending public high schools declined from 23% in 2000 to 14.7% in 2006.

Maryland become a YRBS state 2004. Students completed the first survey in April 2005. The survey was conducted again in 2007, and 2009. For 2009, 18% of high school students taking the YRBS survey reported using some kind of tobacco product on at least one day during the previous 30 days. Nationally the prevalence was much higher at 26%.

# IV. Priorities, Performance and Program Activities

## A. Background and Overview

This section describes Maryland's progress on required national and state performance measures and documents accomplishments, current activities and the State's plan for FY 2011. In many cases, the most current available data is for calendar (CY) or state fiscal year (FY) 2008. Therefore, for many performance measures, we were unable to report on progress for FY 2009. In several instances, the data for the year 2009 will not be available until the fall of 2010 or later. As this data becomes available, it will incorporated into subsequent applications.

In FY 2009. Maryland's Title V Program served approximately 403,228 pregnant women, infants, children, including those with special health care needs and adults. As this report will show, Maryland was able to meet or surpass many of its target objectives for the state's 33 performance and outcome measures. Conversely, measures such as the continued decline in the early prenatal care rates remain as a challenge.

Maryland's MCH Program seeks to improve and enhance the health of all Maryland women, infants, and children including those with special health care needs through funding of Title V and state supported activities and programs. The Program's vision includes a State in which: all pregnancies are planned, all babies are born healthy, all children including those with special needs reach an optimal level of health, and all women and children have access to quality health care services. Title V activities discussed in this document are designed to reflect this vision.

Activities and services are delivered at each level of the MCH pyramid and directed at each of the Title V population groups: pregnant women and infants, children and adolescents, and children with special health care needs. Reducing infant and child mortality and improving health outcomes are Program priorities as described in the next section. All activities and programs are linked to these outcome measures.

## B. State Priorities

Maryland's proposed priority MCH needs for 2011-2015 are:

#1. Women's Wellness: Improve the health and wellness of women during the childbearing years (ages 15-44) to ensure that women are healthy at the time of conception.

Women's wellness or the health of women prior to conception was recognized as an important MCH need by respondents to the MCH Stakeholder Survey and during both rankings at the March Stakeholder meeting. Women's wellness is a broadly focused issue and Title V staff agreed to narrow the focus for purposes of the needs assessment to address reducing unintended pregnancy through provision of family planning services. Maryland is also moving toward enhancing family planning clinical services to include a comprehensive set of women's wellness services not specifically related to or required for contraception or contraceptive management. These include screening and/or services related to chronic disease, nutrition, overweight/obesity, smoking cessation, mental health, substance abuse, domestic violence, preconception planning, or assisting with access to health insurance or primary care. The provision of family planning services also serve as primary prevention strategy for reducing poor birth outcomes. The proposed State Negotiated Performance Measure: Percentage of Maryland mothers with intended pregnancies: 56.6% in 2008 (PRAMS) (also chosen as a priority measure in 2005).

# 2: Healthy Pregnancy, Pregnancy Outcomes and Infants: Promote healthy pregnancies, pregnancy outcomes and infants by reducing risky behaviors (e.g., substance abuse) and improving access to prenatal care.

Reducing infant mortality and related risk factors is a public health priority in Maryland. Significant progress toward reducing infant mortality and improving birth outcomes in Maryland that had been achieved during the 1990's has now stalled, with little improvement made for nearly a decade. Governor O'Malley has identified a 10% reduction in infant mortality in Maryland by 2012 as one of his top policy goals. MCH stakeholders noted that healthy pregnancies and pregnancy outcomes are more likely to occur when mothers are healthy at conception; receive adequate, quality prenatal care; have adequate social and emotional supports; and avoid risky behaviors such as smoking and alcohol and drug use. PRAMS data show that 8% of Maryland women drank in their third trimester of pregnancy. This was viewed as unacceptable by Title V staff and stakeholders and once again, it was decided that additional outreach and education to both women and health care providers is needed. Therefore, the proposed state performance measure remains as: Percentage of women who use alcohol during the last three months of pregnancy (Data source: MD PRAMS Survey)

#3. Healthy Children: Promote early and middle childhood health, healthy child development and parent-child connectedness by increasing access to evidence based home visiting programs

Healthy children require healthy families and/or family support systems, quality early education, safe and nurturing home and learning environments, and access to quality preventive and primary health care. For many Maryland children and families, these requirements have been fully or at least partially met. For others, many challenges exist.

. An estimated one in ten Maryland children ages 0-18 lived in households with incomes below the poverty level in 2008. More than 8,000 Maryland children lived in foster care homes at some point in 2009.
. In 2009, there were 31,206 investigations of child abuse and neglect conducted in Maryland. In 20% of the cases (6,312), the findings were substantiated.
. One in five pregnant women do not receive prenatal care within the first trimester in 2008.
. According to the 2007 National Survey of Children's Health, 41.4% of Maryland children ages 0-17 do not meet the AAP criteria for having a medical home and 6% do not have a usual place for sick and well care.
. Approximately 244,000 Maryland children have special health care needs.

Similar to findings from the 2005 needs assessment, Title V heard about the need to support and strengthen families to assure that children remain healthy and thrive. This need for support is cross-cutting and required for all Maryland families, especially socio-economically disadvantaged families. However, the Title V Program also recognizes that families with young children are especially vulnerable and in need of services that enhance their ability to address their health needs, meet their developmental needs, and support school readiness.

Over the next five years, the Title V Program will promote healthy children by improving access to home visiting programs in areas of greatest risk. The availability of new federal funding provides the state with an opportunity to expand access to evidence based home visiting programs. Improving access to these home visiting programs was identified by stakeholders as a priority primary prevention strategy for poor birth and child health outcomes. The proposed State Performance Measure is the Number of children enrolled in evidence based home visiting programs in Maryland (Data Source: Maryland Title V Program Data).

#4. Access to Health Care for Children: Improve access to preventive, primary, specialty, mental health and oral health care as well as health insurance coverage for all children including those with asthma and other special health care needs

Both data examined for the 2010 population based assessment and comments made by MCH stakeholders through surveys and key informant interviews continually spoke of the need to improve access to health care -- preventive, primary, specialty, mental health, oral health -- for

children and adolescents, particularly those that are low-income and/or uninsured children. Major issues identified include the following the shortages and maldistribution of health manpower, language barriers, transportation, and difficulties, and provider unwillingness to accept Medical Assistance.

These data also continued to reveal unacceptable levels of morbidity and mortality among children in the early and middle childhood periods. Areas of continuing concern included asthma, overweight and obesity, dental caries, and mental health/behavioral problems. This priority was selected to ensure continued focus on improving the health of children in the early and middle years. For example, asthma currently affects approximately 123,000 Maryland children ages 0-17 and is the leading cause of hospitalization for children in the elementary and middle school years as well as leading reason for school absenteeism. Asthma is a controllable disease when properly managed. The use of hospital emergency departments for routine asthma management can be an indicator of poor asthma management. The Maryland Asthma Control Program which is administratively housed in the Center for Maternal and Child Health is implementing a statewide plan to reduce mortality and morbidity from asthma by promoting educational and other to improve asthma management. The use of the hospital emergency department for asthma control will continue to be used as the state performance measure for this priority. Proposed State Negotiated Performance Measure: Rate of emergency department visits for asthma per 10,000 children, ages 0-4: 184 in 2007. This compares unfavorably to the Healthy People 2010 goal of 80.

# 5. Reduce Childhood Obesity: Promote needed actions to reduce overweight and obesity among children and adolescents

Childhood overweight/obesity was identified as a priority issue both in the 2005 and 2010 MCH needs assessment. Since the 2005 needs assessment when reducing overweight and obesity across all age groups was identified as a priority, adult and early childhood obesity rates have continued to rise in Maryland. The White House Task Force on Childhood Obesity, in its May 2010 report to President Obama, called the childhood obesity epidemic in America a national health crisis. Nationally, almost one in every three children (31.7%) ages 2-19 is overweight or obese. The 2007 National Survey of Children's Health estimates that more than one in four Maryland children ages 10-17 are overweight or obese.

Rising rates of childhood overweight and obesity were repeatedly identified as a concern in stakeholder surveys and discussions. Because obesity is continuing to increase, is a leading cause of premature death, and remains a significant risk factor for several chronic conditions including type 2 diabetes, heart disease, cancer and asthma, Title V staff strongly believed that this issue should remain a priority focus area. The proposed State Negotiated Performance Measure: Percent of Maryland Medicaid recipients ages 2-19 years that are obese. (Data Source: Maryland Healthy Kids Obesity Database).

#6: Healthy and Productive Youth and Young Adults -- Transition to Adulthood: Improve supports for the successful transition of all youth to adulthood.

Youth transition to adulthood is one of the six core outcomes identified by the federal Maternal and Child Health Bureau for children and youth with special health care needs (CYSHCN). Both quantitative and qualitative data collected for Maryland's 2010 needs assessment indicate that Maryland is struggling to ensure that all YSHCN receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. According to the 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN), Maryland ranked 42nd in the nation on achieving this core outcome; less than 38% of Maryland families of YSHCN ages 12-17 reported that their child received the services necessary to make appropriate transitions to adult life. Maryland scored below the national average on many other of the 2005-06 NS-CSHCN transition indicators.

Participation in transition planning is an important step for families and YSHCN, and increasing the proportion of parents of YSHCN who report engaging in transition planning from pediatric to adult health care has been identified as a Healthy People 2020 objective. According to the 2008 Maryland Community of Care Consortium for CSHCN 2008 Summit Youth Transition Workgroup, Maryland has multiple activities in the state focused on improving this core outcome, but these attempts seem fractured and do not appear to have a common end goal. The state lacks a clearly defined, comprehensive, coordinated system of care to facilitate success in transitioning YSHCN from pediatric to adult-based health care. The issue is compounded by the problem of youth in this age group accessing their own health insurance. Maryland plans to address these barriers by focusing on training families on the transition process as well as by identifying opportunities for collaboration among agencies and organizations working on youth transition issues in the state. The proposed State Negotiated Performance Measure: The percent of YSHCN families who participate in transition planning for their child: 48% in 2009 (Source: Maryland Parent Survey.)

#7: Strategic Partnerships: Sustain, Strengthen and Maximize Strategic Partnerships through the Community of Care Consortium to address CSHCN core outcomes in Maryland

Supporting the development and implementation of comprehensive, culturally competent, coordinated systems of care for CSHCN has been identified as a critical objective for states by the federal Maternal and Child Health Bureau. State Title V programs have been asked to work with family advocates, providers, and other partners to achieve success on the six core outcomes for CSHCN. In 2008, the Parents' Place of Maryland (PPMD) was awarded a federal "State Implementation Grant for Integrated Community Systems for Children and Youth with Special Health Care Needs" in partnership with the State's Title V program for CSHCN (the Office for Genetics and Children with Special Health Care Needs, or OGCSHCN), the Maryland Chapter of the American Academy of Pediatrics, and the Women's and Children's Health Policy Center at the Johns Hopkins Bloomberg School of Public Health. Through the grant and partnerships, PPMD developed the Maryland Community of Care Consortium for CSHCN (or CoC). Since its inception in the fall of 2008, the CoC Consortium has created a broad alliance of diverse stakeholders in collaborative efforts to improve systems of care for Maryland CSHCN and their families. They oversee and spread the use of evidence-based and best practice strategies both at the state and local levels, using mini-grants to support implementation. Much of the Consortium's work is aligned with the Healthy People 2020 objective to increase the proportion of CSHCN who receive their care in family-centered, comprehensive, coordinated systems.

At a needs assessment stakeholder meeting in March, key Title V CSHCN staff and parent advocates, working together as a group, identified ongoing stakeholder partnerships as the primary method through which several core outcomes for CSHCN in Maryland should be addressed. Earlier in the meeting, a broad collection of stakeholders from across Maryland had selected those core outcomes as top priority needs for the CSHCN population in the state, including medical home, that families receive needed services through easy-to-use, community-based systems of care, and adequate health insurance and financing. Stakeholders agreed that the improvement of CYSHCN outcomes requires a system-oriented, partnership-based approach that incorporates infrastructure, population-based services, enabling services, and direct services. Stakeholders also concurred that the role of the Consortium is essential to the health of Maryland's Title V program, as the state's CSHCN program office has suffered unprecedented personnel erosion and remains understaffed to the point where fulfilling Title V obligations to Maryland's CYSHCN is virtually impossible without the support and leadership of the Consortium. The proposed State Negotiated Performance Measure: Percent of CoC members who report five or more collaborative activities in the previous 12 months; 51.8% in 2008 (Source: Maryland Community of Care Partnership Profile).

#8: Data Systems and Sharing: Improve state and local capacity to collect, analyze, share, translate and disseminate MCH data and evaluate programs

Consistent state level data that indicate the well-being of Maryland's CYSHCN population are crucial to measuring the state's progress on the six core outcomes for this population. However, availability of these data are limited due to agency silo issues and fragmentation among government and non-government agencies and organizations serving the CYSHCN population in Maryland. The data most commonly used to measure Maryland's performance around the six core outcomes are national data from two surveys, the National Survey of Children's Health (NSCH) and the National Survey of Children with Special Health Care Needs (NS-CSHCN). While these surveys provide valuable information every five years and allow state-to-state and state-to-nation comparisons of critical data points and outcomes, they do not provide yearly, statewide, or jurisdiction level data that would help Maryland target resources within the state to improve outcomes for CYSHCN. At a needs assessment stakeholder meeting in March, key Title V CSHCN staff and parent advocates, working together as a group, identified the lack of data sharing among agencies as one of the most significant barriers The need for data sharing and integration in support of MCH populations is recognized in the Healthy People 2010 developmental objective HP2010 23-2: Increase the proportion of Federal, Tribal, State, and local health agencies that have made information available for internal and external public use in the past year based on health indicators related to Healthy People 2010 objectives. The proposed State Negotiated Performance Measure: % of performance measure benchmarks Maryland has reached toward implementing a Data Sharing plan.
and direct services.

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 95 | 95 | 95 | 95 | 99 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 125 | 170 | 182 | 199 | 199 |
| Denominator | 125 | 170 | 182 | 199 | 199 |
| Data Source | | | | NBS databases (NSS, NEST, StarLIMS, Pediatrix | NBS data bases (StarLIMS and Sickle) |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2009**

Newborn screening data is reported by calendar year, CY 2009, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center (NNSGRC).

A new performance measure is formulated as control of newborn screening laboratory testing was returned to the State. HB 216 (2008) gave the State Public Health Laboratory the sole authority to perform first tier newborn screening tests for Maryland babies. The bill went into effect 01/01/2009. 2008 data was fragmented -being collected from 4 different databases in 2 different labs. 2009 data was gathered from only 2 databases.

While we would like to maintain our record of treating 100% of confirmed cases, we are aware that a single case lost to follow up would significantly decrease our performance. It seems unrealistic to believe that a case could never be lost to follow up- although we are very tenacious.

**Notes - 2008**
Newborn screening data is reported by calendar year, CY 2008, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center (NNSGRC).

A new performance measure is formulated as control of newborn screening laboratory testing was returned to the State. HB 216 (2008) gave the State Public Health Laboratory the sole authority to perform first tier newborn screening tests for Maryland babies. The bill went into effect 01/01/2009- so 2008 data is still fragmented -being collected from 4 different databases in 2 different labs. However, data will be better in the coming year being gathered from only 2 databases.

While we would like to maintain our record of treating 100% of confirmed cases, we are aware that a single case lost to follow up would significantly decrease our performance. It seems unrealistic to believe that a case could never be lost to follow up- although we are very tenacious. The number of confirmed cases includes 103 sickling disorders but only 39 of them have "gold standard" confirmation. Only these 39 were reported to the NNSGRC. The remaining 64 have 2 abnormal NBS specimens but no electrophoresis done at over 3 months of age and no DNA.

**Notes - 2007**
Newborn screening data is reported by calendar year, CY 2007, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

A new performance objective is not formulated for the coming year. Problems in obtaining data from the commercial laboratory , insufficient IT resources and the loss of veteran follow up staff have made it almost impossible to compile accurate unduplicated data. The commercial lab does not report all abnormals, only presumptive positives, and they do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they do not always report abnormals, even presumptive positives on home births or babies born to Maryland residents in DC who have their initial screen in DC but their subsequent screen in Maryland, or babies born in Maryland but then transferred to the NICU at Children's National Medical Center in Washington, DC. (Maryland has a 2 specimen system.)

The number of presumptive positives has decreased. New automated pipetting systems for the assays for T4 , TSH , galactosemia and biotinidase have reduced false positives. In addition, growing expertise with tandem mass spectrometry is reducing the false positives in the amino acid and acylcarnitine profiles. Our increasing expertise is due, in part , to courses taken by lab personnel at Duke and Mayo, to an ongiong relationship with Mayo and the "scorecard" project. Other factors include the constant refinement of cut offs, a lab subcommittee of our Advisory Council and the use of new ratios to evaluate abnormal patterns .

New legislation restoring a single newborn screening laboratory will take effect January 2009 and the newborn screening program will be reorganized. These changes make us confident that we can meet higher standards and have better data. Therefore a new objective is chosen for 2010 .

**a. Last Year's Accomplishments**
Newborn screening (NBS) data is reported by calendar year, CY 2009, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

Maryland screens for all the disorders recommended by the ACMG, the AAP and the March of Dimes including the secondary targets, except for Severe Combined Immune Deficiency (SCID) which has just been added to the recommendations. The MD NBS program worked with Drs Jennifer Puck and Kee Chan on the development of the TREC assay when they were at NIH. However, the NBS lab lacks DNA capability and there is no space for a DNA lab. The lab will be moving to a new building in 2011 and will be able to build the required lab and plans to start SCID screening as soon as possible thereafter.

HB 216 (2008) restored sole authority to perform first tier newborn screening tests for Maryland babies to the State Public Health Laboratory and returning to a single lab has made a great improvement. The new StarLIMS NBS database went live late in 2008 but the follow up module was not ready for several months, requiring staff to work with the old and new databases simultaneously. The new module is now fully operational and electronic reporting is working well. We look forward to improved data.

As planned, the short term follow up unit moved to the laboratory in January 2009. The newborn screening fee was increased from $40 to $70 to fund new lab equipment, lab and follow up database computer programming and to support the short term follow up system. The MOU with University of Maryland, Division of Human Genetics, was finalized. A new clinical geneticist for the NBS follow up unit was hired. The genetic counselor position became vacant and was filled. A new on call schedule including UMD staff to taking evening and weekend call in rotation with State NBS staff was approved. New regulations were written and promulgated. The provider manual was updated.

The NBS program follow up works with each child's primary care provider (PCP) and family and makes every effort to find a primary care provider who can provide care in a medical home for each child with a confirmed diagnosis. The unit continues to work with the State genetics / tertiary care centers to provide diagnostic evaluations. The unit also works with the metabolic genetics, endocrine, hematology and CF centers to assure ongoing care for confirmed cases. In FY 2009, the OGCSHCN provided long-term follow-up services including case management, nutritional management, counseling, health education, and family support to 245 families with confirmed metabolic disorders and 1,473 children with sickle cell disease. The genetics centers served over 7,318 individuals and provided 10,059 laboratory services.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Support newborn screening for all the disorders recommended by the March of Dimes, the AAP and the ACMG for all Maryland babies. | X | | X | X |
| 2. Support the newborn screening follow up staff. | X | X | X | X |
| 3. Provide short term follow up assuring that all abnormal or inadequate test results are followed to resolution. | X | X | X | |
| 4. Continue to refine lab testing and follow up protocols. | | | X | X |
| 5. Pursue construction of a DNA lab in the new building. | | | X | X |
| 6. Support the State's designated metabolic, endocrine, hematology and CF centers through small grants. | X | X | X | X |
| 7. Provide metabolic nutritionists from the OGCSHCN to provide | X | X | | |

| | | | | |
|---|---|---|---|---|
| case management and nutritional therapy. | | | | |
| 8. Provide case management for sickle cell disease patients through the 6th birthday and continue to develop resources for transition and care for them as adults. | X | X | X | X |
| 9. Continue work with CNMC on exchange of NBS data to facilitate care for babies with SCD, to improve completeness of State data and for quality assurance purposes. | X | X | X | X |
| 10. Continue to educate providers and parents, update educational materials and enhance the website. | X | X | X | X |

**b. Current Activities**

Legislation advocating mandatory newborn screening was defeated. Maryland families seldom refuse NBS. The Advisory Council on Hereditary and Congenital Disorders (ACHCD) (consumer dominated with expert medical, DHMH and legislative representation) voted to move from informed consent to the informed dissent model used by most other states. Current regulations allow either approach.

The NBS program updated its parent education materials/ website to reflect this change. The website moved to the Laboratories Administration website.

The feasibility study, with Ann Moser, on the NBS for Adrenal Leukodystrophy is close to completion. We hope to initiate ALD screening in the near future.

The ACHCD studied the issue of storage and use of left over blood spots. A comprehensive policy was drafted.

The follow up of babies with abnormal SCD newborn screening results referred to Childrens' National Medical Center suffered when new legal personnel became concerned that reporting the results of the definitive diagnostic work up back to the NBS program might violate HIPAA. Maryland laws mandating reporting back to the NBS program and charging the DHMH with monitoring the baby's health don't apply across state lines. A Data Sharing Agreement was drafted and approved by the Maryland Attorney General but CNMC has yet to sign it.

**c. Plan for the Coming Year**

The NBS staff will continue to improve the new NBS website, adding a section for providers, a training section, a section on residual blood spot storage and use and allowing hospitals and providers to order materials electronically.

The program will continue to pursue the Data Sharing Agreement with CNMC.

The program will continue to refine the residual blood spot policy.

The program is considering the optimal organization of long term follow up activities, particularly for SCD and may reorganize.

Plans for the new lab building will be refined.

A contractual agreement with the Texas newborn screening lab to do DNA analysis on abnormal newborn hemoglobin patterns suggestive of S beta + thalassemia has been concluded and such specimens are being sent for DNA testing. A panel of common mutations is run and if no mutation is seen the gene is partially sequenced. So far many suggestive results have been confirmed as S beta+ thalassemia.

The program continues to refine its lab testing protocols and replace ageing equipment. New and better equipment, a relationship with Mayo and "scorecard" project, the constant refinement of cut

offs, a lab subcommittee of our Advisory Council and the use of new ratios to evaluate abnormal patterns continue to reduce false positives.

The program worked with a genetic counseling student on the educational needs of birthing hospital nurses and will continue to work with researchers on false positives determine how to minimize the negative effects of false positives and to devise an optimal method of informing families about carrier status.

## Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

| **Total Births by Occurrence:** | **76643** | | | | | |
|---|---|---|---|---|---|---|
| **Reporting Year:** | **2009** | | | | | |
| **Type of Screening Tests:** | **(A) Receiving at least one Screen (1)** | | **(B) No. of Presumptive Positive Screens** | **(C) No. Confirmed Cases (2)** | **(D) Needing Treatment that Received Treatment (3)** | |
| | No. | % | No. | No. | No. | % |
| Phenylketonuria (Classical) | 78975 | 103.0 | 15 | 2 | 2 | 100.0 |
| Congenital Hypothyroidism (Classical) | 78975 | 103.0 | 275 | 30 | 30 | 100.0 |
| Galactosemia (Classical) | 78975 | 103.0 | 17 | 1 | 1 | 100.0 |
| Sickle Cell Disease | 78975 | 103.0 | 106 | 104 | 104 | 100.0 |
| Biotinidase Deficiency | 78975 | 103.0 | 22 | 1 | 1 | 100.0 |
| Cystic Fibrosis | 78975 | 103.0 | 101 | 15 | 15 | 100.0 |
| Homocystinuria | 78975 | 103.0 | 146 | 0 | 0 | |
| Maple Syrup Urine Disease | 78975 | 103.0 | 25 | 0 | 0 | |
| Other | 78975 | 103.0 | 2 | 1 | 1 | 100.0 |
| beta-ketothiolase deficiency | 78975 | 103.0 | 0 | 0 | 0 | |
| Tyrosinemia Type I | 78975 | 103.0 | 106 | 0 | 0 | |
| Very Long-Chain Acyl-CoA Dehydrogenase Deficiency | 78975 | 103.0 | 2 | 0 | 0 | |
| Argininosuccinic Acidemia | 78975 | 103.0 | 5 | 0 | 0 | |
| Citrullinemia | 78975 | 103.0 | 5 | 2 | 2 | 100.0 |
| Isovaleric | 78975 | 103.0 | 4 | 1 | 1 | 100.0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Acidemia | | | | | | |
| Propionic Acidemia | 78975 | 103.0 | 95 | 0 | 0 | |
| Carnitine Uptake Defect | 78975 | 103.0 | 0 | 0 | 0 | |
| 3-Methylcrotonyl-CoA Carboxylase Deficiency | 78975 | 103.0 | 19 | 2 | 2 | 100.0 |
| Methylmalonic acidemia (Cbl A,B) | 78975 | 103.0 | 104 | 0 | 0 | |
| Multiple Carboxylase Deficiency | 78975 | 103.0 | 0 | 0 | 0 | |
| Trifunctional Protein Deficiency | 78975 | 103.0 | 2 | 0 | 0 | |
| Glutaric Acidemia Type I | 78975 | 103.0 | 2 | 1 | 1 | 100.0 |
| Sickle Cell Anemia (SS-Disease) | 78975 | 103.0 | 68 | 62 | 62 | 100.0 |
| 21-Hydroxylase Deficient Congenital Adrenal Hyperplasia | 78975 | 103.0 | 385 | 1 | 1 | 100.0 |
| Medium-Chain Acyl-CoA Dehydrogenase Deficiency | 78975 | 103.0 | 13 | 5 | 5 | 100.0 |
| Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency | 78975 | 103.0 | 2 | 1 | 1 | 100.0 |
| 3-Hydroxy 3-Methyl Glutaric Aciduria | 78975 | 103.0 | 0 | 0 | 0 | |
| Methylmalonic Acidemia (Mutase Deficiency) | 78975 | 103.0 | 104 | 0 | 0 | |
| S-Beta Thalassemia | 78975 | 103.0 | 6 | 4 | 4 | 100.0 |

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 70 | 71 | 72 | 55 | 55.5 |
| Annual Indicator | 68.1 | 68.1 | 54.8 | 54.8 | 54.8 |
| Numerator | 142329 | 142329 | | | |
| Denominator | 209000 | 209000 | | | |
| Data Source | | | | SLAITS 2005-2006 | SLAITS 2005-2006 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 56 | 56.5 | 57 | 57 | 57 |

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2008**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual Performance Objectives have been revised based on the most recent data.

**a. Last Year's Accomplishments**
According to the 2005-06 National Survey of CSHCN (NS-CSHCN), just under 55% of Maryland families of CYSHCN report that they are partners in decision-making and are satisfied with the services they receive, compared with over 57% nationally. On the 2001 NS-CSHCN, over 68% of families of CYSHCN reported success in this outcome. Family-professional partnerships and satisfaction with care have traditionally been areas of relative strength for Maryland compared with other states. The reasons for this change as reflected on the NS-CSHCN are unclear.

The OGCSHCN continued its support of The Parents' Place of Maryland (PPMD), a non-profit, family-directed and staffed center serving parents of children with disabilities and special health care needs. PPMD houses the Maryland Chapter of Family Voices. PPMD and OGCSHCN have an ongoing partnership in a number of activities, including the Family-to-Family Health Education and Information Center, a statewide resource about the health care system which provides information, support, advocacy, and referrals for families of CYSHCN. In FY09, PPMD parent staff provided individual assistance to 753 parents of CYSHCN and 363 professionals through telephone, email, and face-to-face meetings. PPMD has fostered relationships with a number of organizations connected with ethnic/racial minority populations and provides materials and trainings in Spanish and uses community contacts for translation in other languages. PPMD has been very successful in its minority outreach efforts; 39% of those served were minority parents. PPMD held a statewide parent conference in Spanish in June 2009, planned in conjunction with

Latino providers, and 60 individuals attended. They also conducted 4 smaller workshops in Spanish for parents of CYSHCN. PPMD sends out a monthly newsletter (ParenTalk) covering both health and education topics that reaches at least 18,000 individuals in FY09.

PPMD continued the Family as Faculty program this year with UMD School of Medicine and Johns Hopkins School of Public Health, facilitating home visit matches followed by a debriefing for pediatric residents and students with diverse families of CSHCN on a monthly or bi-monthly basis. Evaluations of this program continue to be positive. Last year, PPMD conducted a variety of workshops for both parents and professionals aimed at increasing partnership and advocacy skills and effectively accessing health care services for CYSHCN. In FY09, PPMD conducted 29 regional workshops and trainings across the state for 1820 participants including parents and providers. PPMD also held a parent information/education conference in Harford County for 20 parents.

OGCSHCN support enables PPMD to identify and support emerging parent leaders to participate in leadership and policymaking activities through sponsored parent participation in the B'more and Health LEADers programs. LEADers graduates are then linked with various state and local committees, councils, and task forces to provide a family perspective. OGCSHN support also enables PPMD staff to participate in a number of venues, providing parent input into health policy and program design activities. In FY09, B'More Leaders participated in more than 50 committees or council meetings and assisted more than 300 individual parents, providing information, resources, and support.

PPMD staff directly contributed to the writing and review of last year's Title V MCH Block Grant report and application, and PPMD's Executive Director attended the Block Grant review with Maryland's Title V team at MCHB. Parents also provide representation on many statewide, multi-agency committees as well as a number of local committees.

OGCSHCN continued to work with PPMD on their State Implementation Grant for Integrated Community Systems for CYSHCN. A part-time OGCSHCN staff member provided leadership/staff support to continue the activities of the Maryland Community of Care (CoC) Consortium for CYSHCN. The CoC holds quarterly meetings and identifies priorities, including building relationships between families and professionals through education and joint training. The CoC facilitated family-professional partnerships by having parents participate in provider workshops/trainings on early and continuous screening for special health care needs and medical home.

OGCSHCN employed two parents of CSHCN. The parent of an adult with Sickle Cell Disease works in SCD follow-up, and another parent headed the Birth Defects Reporting.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Support The Parents' Place of Maryland to provide families of CYSHCN with a central source of information, education, direct family support and referrals | | X | | X |
| 2. Support The Parents' Place of Maryland to provide parent training, including Health TIES (Training, Information, Education, and Support) program | | X | | X |
| 3. Support parent input into health policy and program design activities | | | | X |
| 4. Support employment of family members of CYSHCN | | X | | X |
| 5. Collaborate with partners to collect data and information from families of CYSHCN via multiple sources | | | | X |

| | | | | |
|---|---|---|---|---|
| 6. Support The Parents' Place of Maryland to maintain and expand a Families as Faculty Program | | | | X |
| 7. Work with The Parents' Place of Maryland and other stakeholders to further develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports family-professional partnerships | | | | X |
| 8. Disseminate materials and resources that promote Family-Centered Care. | | | | X |
| 9. Include parents in developing the Title V Needs Assessment | | | | X |
| 10. Include parents in preparing the Title V Block Grant application | | | | X |

**b. Current Activities**

OGCSHCN supports programs that gather data/information from families of CYSHCN to assess their needs and ensure that families have a voice in program/policy decisions. An OGCSHCN staff person partnered with CMCH and PPMD to develop a statewide survey of parents of CSHCN as part of the 2010 Title V Needs Assessment. Families had multiple ways in which to access the survey: paper, online, and in-person. Parents were hired to conduct the survey in-person in areas which often have low response rates, i.e. southern Maryland, Prince George's County, Baltimore City, and the lower Eastern Shore. Gathered data was used in the Title V Needs Assessment and will continue to be analyzed and disseminated to CYSHCN stakeholders and parents through reports and presentations. The OGCSHCN continues to provide staff support to the CoC, though it has been severely reduced due to staffing shortages. The CoC continues to hold quarterly meetings, and members, including families of CYSHCN, contributed to the development of the parent survey. The CoC disseminated and promoted the use of the Family Voices Family Centered Care Self-Assessment Tools at a meeting of 35 members in July 2009. PPMD was integral in the Title V Needs Assessment process and had critical input at each phase of the project: staff helped identify the final CYSHCN priorities for the state and to develop associated performance measures and also provided assistance in preparing the MCHB Title V Block Grant for this application year

**c. Plan for the Coming Year**

The activities described will continue. OGCSHCN is currently undergoing a reorganization. Vacant staff positions will continue to limit the capacity of OGCSHCN to make progress on this core outcome. PPMD will continue to work closely with Title V CSHCN staff to develop and implement action plans for each of the newly identified state priorities, one of which is to strengthen and sustain partnerships, including parent partnerships. The CoC will collaboratively plan implementation and evaluation strategies to achieve and sustain an integrated, community-based system of services for CYSHCN and their families. Support of family-professional partnerships and cultural competency will be integral to these activities. The CoC is a racially, ethnically, culturally, linguistically, socioeconomically, and geographically diverse group, including the parents and other family members of CYSHCN. Their charge is identifying and implementing strategies to promote family-professional partnerships and cultural competency in all of their activities. The Mini-Grant program (grants to be awarded for community implementation during the Project) of the CoC requires family participation and strategies for cultural competency in all projects.

Family members are required participants in all activities. Family members serve as members of CoC community teams for the CYSHCN Learning Collaboratives for developmental screening and follow-up. New family members will be paired with experienced parent professionals (PPMD regional parent coordinators) for mentorship and support. Mentors will assess the information and training needs of new family members and provide individual/group training and include them in the leadership training activities of PPMD's Family-to-Family Health Education and Information Center. Families receive stipends for their participation and reimbursement for travel/childcare. The CoC strives to accommodate special needs of its members including sign and foreign

language interpretation. PPMD has Spanish-speaking staff to provide interpretation and translation of written materials.

The Title V CSHCN program will include PPMD in preparing the MCHB Title V Block Grant for 2011 and in developing Action Plans around state and national priorities identified in the Title V 2010 Needs Assessment. In addition, OGCSHCN and PPMD have preliminary plans to develop a Family Advisory Council for the Title V CSHCN program.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 60 | 61 | 62 | 46 | 46.5 |
| Annual Indicator | 56.3 | 56.3 | 45.6 | 45.6 | 45.6 |
| Numerator | 117667 | 117667 | | | |
| Denominator | 209000 | 209000 | | | |
| Data Source | | | | SLAITS 2005-2006 | SLAITS 2005-2006 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 47 | 47.5 | 48 | 48 | 48 |

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**Notes - 2008**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**a. Last Year's Accomplishments**
OGCSHCN continues to assist children and families who are identified and receive services through its programs in finding a medical home, including children identified by the metabolic and

hearing screening programs, the birth defects program and those served in the Children's Medical Services (CMS) specialty care payment program. OGCSHCN continues to support the Centers of Excellence programs in systems development activities to promote of medical home. The Complex Care Program at Children's National Medical Center supports medical homes by bridging/filling the gap between primary care providers and tertiary services provided by the medical center. Both clinical and care coordination services are offered. In FY09 there were 381 visits (including clinic and hospital) for 370 patients, of which 114 were new to the program. Johns Hopkins University Systems Development for CSHCN focuses on patients at Harriet Lane Clinic with asthma, ADHD, and SCD and has developed a system to identify and electronically track them. Care managers are assigned to work with those patients and their families to coordinate services and treatment with hospitals and other providers, and they have developed a system of enhanced communication between HLC providers and specialists. Pediatric residents at HLC receive multiple trainings on the medical home model.

OGCSHCN continued to work with PPMD on their State Implementation Grant for Integrated Community Systems for CYSHCN. A part-time OGCSHCN staff member provided leadership/staff support to continue the activities of the Maryland Community of Care (CoC) Consortium for CYSHCN. The inaugural summit for the CoC was held in November 2008 and was attended by over 100 physicians, other professionals, and families. Participants worked in small groups. The Medical Home Workgroup focused on improving access to medical homes for CSHCN. They identified and prioritized strategies to improve access to medical homes statewide. Medical home training and education is a focus of the Consortium, and in April 2009 the CoC held a quarterly meeting for 45 participants which focused on medical home in Maryland. Presentations and discussions about medical home implementation from various perspectives took place. CoC members brainstormed about what is already being done and what other steps can be taken to further Medical Home in their community. The CoC also funded a project through their mini-grants program to Dundalk Pediatrics to conduct focus groups of school nurses in that service area to identify common needs and approaches to working together.

PPMD, through their Family as Faculty program in partnership with UMD School of Medicine and Johns Hopkins School of Public Health, facilitates home visit matches followed by a debriefing for pediatric residents and students with diverse families of CSHCN on a monthly or bi-monthly basis. In the debriefings with a PPMD staff person, students are provided with information on the medical home concept and the need for families of CYSHCN to have a medical home.

Improving the system of care coordination through local health departments (LHDs) has continued to be an OGCSHCN priority. Unfortunately, due to ongoing budget cuts, the capacity of the LHDs to provide care coordination for CYSHCN continues to shrink. With OGCSHCN support, in FY09 14 LHDs provided case management services for a total of 1169 CSHCN and their families. Also 15 LHDs provided respite care in FY09 to 634 CSHCN and their families.

The Baltimore City Health Department (BCHD), with continued support from OGCSHCN, expanded its "Medical Homes Project" aimed at improving the quality of medical homes for children in Baltimore City. This project works to improve the rates with which pediatric primary care providers in Baltimore City effectively screen young children for developmental delays and strengthens the linkages between pediatric primary care providers and BCHD resources that can support the health and development of young children at risk. In FY09 the project conducted "public health detailing" with 14 primary care sites across Baltimore City, and continued to retrain 3 primary pediatric care sites on developmental screening and referrals. The project also analyzed collected data on rates of developmental screening and referrals in one of the pilot practices, the Harriet Lane Clinic which resulted in interesting findings. An article describing the findings was published in a peer-reviewed journal in FY10.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Work with families receiving services through the OGCSHCN to find medical homes | | X | | |
| 2. Support the Complex Care Program at Children's National Medical Center | X | X | | X |
| 3. Support efforts to educate families and providers about medical home partnerships through dissemination of materials and conducting trainings and presentations | | X | | |
| 4. Fund gap-filling care coordination for CYSHCN through local health departments, and make needed quality improvements to the system | | X | | X |
| 5. Support multiple efforts to improve developmental screening and appropriate referral for all children within the medical home through policy-level and practice-level change | | X | | X |
| 6. Work with The Parents' Place of Maryland and other stakeholders to continue with the Community of Care Consortium for CYSHCN in Maryland that promotes and supports medical home improvement | | | | X |
| 7. Support Johns Hopkins University in the development of a medical home model for selected high prevalence, high impact and/or high cost conditions within the Harriet Lane Clinic | X | X | | X |
| 8. Support The Parents' Place of Maryland to maintain and expand a Families as Faculty Program that incorporates medical home education for medical and public health students | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Plans for this year had involved hiring another staff person at OGCSHCN to work on the State Implementation grant, however this did not occur, and progress on the medical home goal for the CoC and for the state on this national performance measure has been impeded. The Maryland chapter of the American Academy of Pediatrics (MD AAP) and the CoC had plans to partner in a series of 4 regional forums to bring together physicians, allied health providers, local health departments, community service providers, families, and others to discuss medical home and the integration of medical home approaches into the pediatric practices in their regions. A statewide medical home summit was to have been held in October to bring stakeholders as well as state policy staff together but to date no summit or forums have been held. The OGCSHCN Director and another staff member attended the NICHQ Jumpstart training with Dr. Tracy King and PPMD staff to formulate plans to develop a different approach to improving access to medical home through existing partnerships with pediatric practices participating in the aforementioned Medical Homes Project. The project expanded this year to include at minimum an additional 10 practices.

**c. Plan for the Coming Year**

The activities described above will continue. OGCSHCN is currently undergoing a reorganization. There have been several challenges within the OGCSHCN related to improving outcomes on this national performance measure. The office's Medical Homes Project Coordinator position has been vacant since November 2008, and the Associate Medical Director position - which was responsible for implementing medical home leadership activities in the state -- has been vacant since December 2008. Whether or not these positions are filled depends largely on how the Family Health Administration within DHMH chooses to restructure the OGCSHCN and the details of the reorganization are not known at this time.

Since the OGCSHCN has been so grossly understaffed, PPMD has taken greater responsibility

for implementation of the medical home strategies of the CoC. Despite the best efforts of PPMD, the staffing issues in the state's Title V CSHCN program and the lack of participation from the MD AAP have had negative impacts on CoC plans for medical home improvement strategies.

The Medical Homes Project will continue to operate and expand into more practices with the support of the CoC, PPMD, and OGCSHCN. One of the participating groups, Johns Hopkins Community Physicians (JHCP), would like to implement the program statewide in all 18 of their practices. This will move the program into other areas of the state in addition to Baltimore City. It will also allow the project to train family practitioners (FPs) in addition to pediatricians -- approximately half of the practices in JHCP do not have pediatricians so children are seen by FPs. A new group, Baltimore Medical Services, is joining the project and would like to implement it at all 6 of their practices that serve children. One of the currently participating practices, East Baltimore Medical Center (EBMC) has expressed an interest in branching out from the already implemented improved developmental screening and referral processes and incorporating more medical home building processes. This was a major goal of this project from the start and is an encouraging development.

MD AAP is moving forward with the regional medical home forums originally planned for FY09 and again for FY10. OGCSHCN is providing staff support at each of the meetings and PPMD is providing support and regional data from the Needs Assessment Parent Survey. The forums are scheduled throughout July and August of FY11. An OGCSHCN staff person is presenting CSHCN data at the Infant Hearing Stakeholders meeting in July. The focus of this year's meeting is Medical Home.

OGCSHCN also plans to focus on data gathering and integration as it relates to medical homes in the state. An action plan will be developed to identify potential and existing sources of data and to gain access to and integrate that data to better track progress on medical home outcomes in Maryland.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 70 | 70 | 70.5 | 65.7 | 65.9 |
| Annual Indicator | 67.5 | 67.5 | 65.5 | 65.5 | 65.5 |
| Numerator | 141075 | 141075 | | | |
| Denominator | 209000 | 209000 | | | |
| Data Source | | | | SLAITS 2005-2006 | SLAITS 2005-2006 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 66.1 | 66.3 | 66.5 | 66.5 | 67 |

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2008**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual Performance Objectives have been revised based on the most recent data.

**a. Last Year's Accomplishments**
According to the 2005-06 NS-CSHCN, most CYSHCN in Maryland have health insurance (97%); however underinsurance is a challenge for many families as one-third of families of CYSHCN in Maryland report that their child does not have adequate health insurance to meet her/his needs.

In the past year, the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) continued to partner with The Parents' Place of Maryland (PPMD) and its Family-to-Family Health Information and Education Center. One of the goals of this center is to increase the knowledge and skills of parents/caregivers of CYSHCN so that they may more effectively access health car services for their children. PPMD has developed and has been continuously refining health-related workshops for families, several of which are related to insurance issues including "Choosing a Health Care Plan", "Getting Needed Services from your Health Plan", "Appealing Health Plan Decisions", and "Understanding Medical Assistance in Maryland." These workshops are scheduled on an ongoing basis throughout the state, both face-to-face and by teleconference. In FY09, PPMD staff conducted 29 workshops for a total of 1820 participants. PPMD staff members are also available to provide individual assistance to parents of CYSHCN through telephone, email, and face-to-face meetings. In FY09, individual contact was provided to 1,116 parents and professionals. Among parents, two of the top concerns were obtaining funding to pay for needed services and assistance in accessing appropriate providers.

OGCSHCN continues its partnership with PPMD in the Maryland Community of Care (CoC) Consortium for CSHCN. The CoC is funded through a State Implementation grant awarded to PPMD, and adequate health insurance and financing is one of the core outcomes upon which the CoC is focused. During the inaugural summit for the CoC in November 2008, a group of stakeholders from around the state including representatives from Medicaid, Special Needs Coordinators from Maryland MCOs, and parents and professionals from other organizations identified barriers to adequate insurance and financing in Maryland. They found that overall, Maryland lacks a comprehensive plan to address how services for CYSHCN are paid for and that there is inadequate synthesized data to use for problem identification. Other noted challenges to progress on this outcome were an uneven geographic distribution of providers; the complexity of the system makes it difficult for families and providers to navigate it; a lack of clarity about eligibility for services; insurance is not keeping pace with technological advances in therapy or durable medical equipment; and there has been an erosion of employer-based benefits due to economic distress.

OGCSHCN continued to support Maryland's two medical daycare centers. In FY09 these centers served a total of 97 CSHCN.

The OGCSHCN provided payment for specialty care and related services through the Children's

Medical Services Program (CMS) to Maryland CYSHCN who are uninsured or underinsured and have family incomes up to 200% FPL. Recent changes to the program's eligibility guidelines, which allow the program's income eligibility to automatically update each year in accordance with the new federal poverty guidelines, as well as the continued presence of two bilingual staff served to increase the number of eligible children for the program. In FY09, CMS processed 252 applications and paid for services for 223 CYSHCN. The vast majority of the children served by the program are Hispanic immigrants. The program's Spanish-speaking staff, the Bilingual Outreach Coordinator and the Care Coordinator for Montgomery County, worked directly with families and providers to facilitate access to timely and appropriate CMS program services. The capability to directly provide Spanish-language services to CMS families continued to be invaluable to the program, and has promoted greater parent-program communication as well as an increased parent education/awareness of related program services.

MA/EPSDT, and the Maryland Chapter of the American Academy of Pediatrics (MDAAP) continued the Assuring Better Child Health and Development (ABCD) Screening Academy. The Academy pursued better insurance coverage of developmental screening.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Support The Parents' Place of Maryland to educate parents of CYSHCN about health insurance and how to access services for their children through a series of workshops | | X | | X |
| 2. Support parent input into policy and program design activities related to health insurance for CYSHCN | | | | X |
| 3. Provide payment for specialty care and related services for CYSHCN who are uninsured or underinsured with family incomes up to 200% FPL through the Children's Medical Services Program | X | X | | |
| 4. Provide outreach and case management to Hispanic families through bilingual staff in Children's Medical Services program | | X | | |
| 5. Partner with Medicaid and private insurers to implement policy changes that support improvements in developmental screening, including coding and reimbursement | | | | X |
| 6. Work with The Parents' Place of Maryland and other stakeholders to continue with the Community of Care Consortium for CYSHCN in Maryland that promotes and supports adequate insurance and financing | | | | X |
| 7. Partner with The Parents' Place of Maryland and the Center for Maternal and Child Health to gather data from Maryland families of CSHCN on insurance and out-of-pocket costs. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Plans for this year involved hiring another staff person at OGCSHCN to work on the State Implementation grant, however this did not occur, and progress on the adequate insurance goal for the CoC and for the state has been impeded. As part of the Baltimore Medical Homes project, which the CoC is assisting the Baltimore County Health Department and Tracy King with, a strategic effort was made to have Medicaid MCOs include higher reimbursement rates for providers for developmental screenings. CMS updated its record keeping and would very much like to work toward an electronic payment system, which is crucial as some hospitals/facilities

decline payment that requires only paper claims to file. This decreases the number of service providers that can be accessed by families within the program. CMS has been unable to update its billing system due to a lack of resources. CMS staff advocate for CSHCN in the program and work with hospital billing staff/insurance providers to pay claims and sometimes to cover insurance premiums for CSHCN who qualify for MHIP. It is more cost effective to cover such premiums than to pay for individual services. An OGCSHCN staff person partnered with the Maryland CMCH and PPMD to develop a statewide survey of parents of CYSHCN as part of the 2010 Title V Needs Assessment. Several questions on the survey focused on insurance, delayed or unmet need for medical and other services, problems related to acquiring insurance, and out-of-pocket costs for families.

**c. Plan for the Coming Year**

The activities described above will continue. OGCSHCN is currently undergoing a reorganization. Staffing issues will continue to be a challenge in the coming year, as the Bilingual Outreach Coordinator for CMS resigned near the end of FY2010 and the position has not been filled. Until the position is filled, there will be a reduced capacity in CMS to serve the many Spanish-speaking families that use the program.

The aforementioned parent survey for the needs assessment is complete and OGCSHCN plans to work with PPMD to prepare several issue-specific analyses of gathered data. One such issue is adequate insurance and financing. Plans for analyses include looking for significant differences in responses among families and CYSHCN with different types of insurance, as well as a specific analysis of questions pertaining to insurance, delayed or unmet needs, and out-of-pocket costs. Findings will be disseminated to stakeholders through the CoC and other OGCSHCN partners.

The CoC, through the State Implementation grant, will continue to look for opportunities to positively impact this core outcome. PPMD will continue to provide health-related workshops for families, several of which are related to insurance issues including "Choosing a Health Care Plan", "Getting Needed Services from your Health Plan", "Appealing Health Plan Decisions", and "Understanding Medical Assistance in Maryland" across the state.

With the current state of flux in OGCSHCN, it is difficult to further state what activities the Title V CSHCN program in Maryland will undertake with regards to adequate insurance and financing. Current Title V CSHCN staff will continue to look for opportunities to positively impact this core outcome in the state. The Maryland Secretary of Health and Mental Hygiene, John M. Colmers, a health economist, is very involved in analyzing the probable effect of the recent health care reform legislation on the financing of health care for CYSHCN and the need for safety net services in Maryland and at the federal level.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 75.5 | 89.5 | 89.7 |
| Annual Indicator | 70.6 | 70.6 | 89.3 | 89.3 | 89.3 |
| Numerator | 147554 | 147554 | | | |
| Denominator | 209000 | 209000 | | | |
| Data Source | | | | SLAITS 2005-2006 | SLAITS 2005-2006 |
| Check this box if you cannot report the | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 89.9 | 90.1 | 90.3 | 90.3 | 90.5 |

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2008**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Annual Performance Objectives have been revised based on the most recent data.

**a. Last Year's Accomplishments**
Over the past year, the OGCSHCN continued to support selected outreach specialty clinics throughout the state, including genetics, developmental pediatrics, and endocrinology clinics. However, it has become increasingly difficult to maintain the infrastructure for these clinics. Both the continued availability of funding and sub-specialty wo/manpower to staff the clinics remain areas of concern. In FY09, an estimated 823 individuals were served in 18 specialty outreach clinics for CYSHCN and supported by the OGCSHCN.
The OGCSHCN has also continued its efforts to address the need for assistance with "navigating the system" i.e. finding and accessing available resources within the community. The OGCSHCN provides grant funding to four Centers of Excellence (COE) in Maryland and Washington, D.C. to support a Resource Liaison or similar personnel at each center whose function is to assist families of CYSHCN to locate needed resources within the centers and in the community. The ASK program (Access for Special Kids) at the University of Maryland places one nurse in the pediatric primary clinic, and one nurse in the specialty clinics to assist families with finding resources and coordinating care. The Resource Liaison works closely with Children's Medical Services (CMS) staff to coordinate care for children within the program. The Resource Liaison at Children's National Medical Center (CNMC) works as part of the Complex Care Program (CCP.) Last year, the CCP saw 370 children and provided information about a variety of community resources to their families. The Resource Finder program at Kennedy Krieger is funded in part by OGCSHCN. In FY09 they fielded 1138 inquiries from caregivers, consumers, and providers. The most frequently requested information was regarding providers and services.
In FY09, grants from the OGCSHCN funded gap-filling care coordination for CYSHCN in a number of jurisdictions; 1,169 children were served by staff in fourteen Local Health Departments. Grant funds from the OGCSHCN also provided 634 children with respite care in fifteen counties throughout the state. For example, Somerset County provided camp scholarships in local communities for CSHCN to attend programs with their typically developing peers, and facilitating

easy-to-use community-based services for CYSHCN. The OGCSHCN also continued to provide funding to The Parents' Place of Maryland (PPMD) to expand its Family-to-Family Health Information and Education Center, which operates a toll-free information and referral line as well as a network of parent representatives throughout the state who are available to work one-on-one with families of CYSHCN. A similar "Children's Resource Line" is answered by staff at the OGCSHCN. PPMD conducted "Finding Community Resources" and "Managing the Maze" workshops for parents across the state.

OGCSHCN continued to support the operation of two medical day care centers that served 97 medically fragile infants and young children in FY09. These unique centers provide quality childcare, nursing, and developmental services to children whose medical needs are too great to be served in traditional day care settings, allowing their caregivers to return to work.

A "Padre, Tu Puedes" Conference held in June 2009 was developed by OGCSHCN, PPMD, and other partners and was conducted entirely in Spanish to maximize parent participation, education, understanding and confidence. OGCSHCN Community Systems Development Coordinator was instrumental in the planning and made two presentations. Topics included "How to Advocate for Your Child", "Special Education: Your Rights and the Law", and "Children's Medical Services Program." Over 60 people attended the event.

Regional meetings conducted by OGCSHCN staff in March 2009 focused on community resources and the development of collaborative relationships among local health departments in a given region. Such relationships and collaborations have become vital given the current economic climate.

OGCSHCN continues its partnership with PPMD in the Maryland Community of Care (CoC) Consortium for CSHCN. The CoC is funded through a State Implementation grant awarded to PPMD, and family access to care for CYSHCN that is part of an integrated, community-based system of services is one of the core outcomes upon which the CoC is focused. that service area to identify common needs and approaches to working together.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Support selected subspecialty outreach clinics throughout the state | X | X | | |
| 2. Support a Resource Liaison or similar personnel at 4 Centers of Excellence, and The Parents' Place of Maryland for outreach, information, and referral to families and providers | X | X | | X |
| 3. Support the operation of 2 medical day care centers serving medically fragile infants and young children | X | X | | |
| 4. Support the local health departments and parent organizations to provide a variety of respite services to families of CYSHCN | | X | | |
| 5. Fund gap-filling care coordination for CYSHCN through local health departments, and make needed quality improvements to the system | | X | | X |
| 6. Work with partners to update web-based county-specific resource lists for each jurisdiction and disseminate | | X | | X |
| 7. Work with The Parents' Place of Maryland and other stakeholders to continue with the Community of Care Consortium for CYSHCN in Maryland that promotes and supports easy to use, community-based service systems | | | | X |
| 8. Sponsor regional meetings for local health departments to | | | | X |

| | | | | |
|---|---|---|---|---|
| develop collaborative relationships | | | | |
| 9. Partner with The Parents' Place of Maryland and the Center for Maternal and Child Health to gather data from Maryland families of CSHCN on whether families are receiving needed services | | | | X |
| 10. | | | | |

**b. Current Activities**

OGCSHCN continued to support local health departments for respite care and care coordination close to home as well as many specialty clinics in the Maryland and Washington, D.C. region. OGCSHCN granted money to the Kent County Health Department to conduct a needs assessment of CYSHCN in the county during FY2010. It is likely that as a result of this needs assessment, OGCSHCN will provide support for care coordination, respite or other needed services in coming years. OGCSHCN conducted a regional meeting with LHD staff in September 2009 for central Maryland. OGCSHCN will continue to promote collaborative relationships among local health departments to maximize services for CSHCN, especially in rural, underserved communities. Plans for this year had involved hiring another staff person at OGCSHCN to work on the State Implementation grant, however this did not occur, and progress on this core outcome for the CoC and for the state on this national performance measure has been impeded. OGCSHCN Centers of Excellence grantees and PPMD met with staff to coordinate activities. An OGCSHCN staff person partnered with the Maryland Center for Maternal and Child Health and PPMD to develop a statewide survey of parents of children with special health care needs in Maryland as part of the 2010 Title V Needs Assessment. Several questions on the survey focused on easy to use, community-based systems of care.

**c. Plan for the Coming Year**

The activities described above will continue. OGCSHCN is currently undergoing a reorganization. Staffing issues will continue to be a challenge in the coming year, as the OGCSHCN Community Systems Development Coordinator resigned near the end of FY2010 and the position has not been filled. Until the position is filled, there will be a reduced capacity to sponsor regional meetings and to foster collaborative relationships among LHDs and to address concerns at regional meetings. OGCSHCN will hold a mandatory retraining for all of its grantees to inform them of new state Title V priorities, findings from the Title V 2010 Needs Assessment, new grant reporting requirements, and an information session on core outcomes for CYSHCN. Grantees will also have an opportunity to share progress and outcomes as well as coordinate future activities.

The aforementioned parent survey for the needs assessment is complete and OGCSHCN plans to work with PPMD to prepare several issue-specific analyses of gathered data. One such issue is families receiving needed services through community-based systems of care that are easy to use. Plans for analyses include looking for significant differences in responses about receiving needed services among families and CYSHCN in different regions of the state, and a qualitative analysis of responses to open-ended questions pertaining to this core outcome. Findings will be disseminated to stakeholders through the CoC and other OGCSHCN partners and will be used to inform state activities around this performance measure.

As part of the five year Title V Needs Assessment process, state priorities for CSHCN were identified and disseminated for public feedback. The Maryland chapter of the American Academy of Pediatrics commented that the state should highlight the need for communication, integration, and coordination of services from multiple providers and systems, which could potentially improve quality and reduce cost by eliminating redundant or unnecessary services. OGCSHCN and the CoC plan to approach the MD AAP about ways in which our organizations could work together toward this goal.

The CoC, through the State Implementation grant, will continue to look for opportunities to positively impact this core outcome. With the current state of flux in OGCSHCN, it is difficult to

further state what additional activities the Title V CSHCN program in Maryland may undertake with regards to promoting community-based systems of care for CYSHCN that are easy to use. Current Title V CSHCN staff will continue to look for opportunities to positively impact this core outcome in the state.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 10 | 11 | 12 | 38 | 38.5 |
| Annual Indicator | 5.8 | 5.8 | 37.5 | 37.5 | 37.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | SLAITS 2005-2006 | SLAITS 2005-2006 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 39 | 39.5 | 40 | 40 | 40.5 |

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2008**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Annual Performance Objectives have been revised based on the most recent data.

**a. Last Year's Accomplishments**
The 2005-06 NS-CSHCN estimates that 37.4% of Maryland CYSHCN ages 12-17 receive the services necessary to transition to the adult world compared with 41.2% nationally. There were significant differences between this and the 2001 NS-CSHCN but Maryland still ranks only 42nd among the states, only slightly better than ranking 44th in 2001.

The OGCSHCN continued to promote successful health care transition for youth with sickle cell disease (SCD) and diabetes (DM) through support of transition clinics at the Johns Hopkins Hospital. Youth with SCD 18 to 24 years of age are cared for jointly by the pediatric and adult hematologists, in the transition clinic in the Department of Internal Medicine, prior to transfer of care to the adult hematology clinic. In FY09, the SCD transition clinic provided 25 visits to 63 patients. The transition clinic for youth with DM targets patients in their last year of high school. In this model, parents and youth are introduced to the adult endocrinologist at the transition clinic. The adult endocrinologist meets with the patients and their parents both with and without the pediatric endocrinologist. In FY09, the clinic held a total of 18 transition clinic sessions. The program treated 26 patients and transitioned 6 patients. Fewer patients were seen and transitioned than in previous years due to the resignation of the adult endocrinologist; another provider was hired and the program expects to see and transition more patients in FY10.

OGCSHCN staffs the Statewide Steering Committee on Services for Adults with Sickle Cell Disease established in 2007 under Maryland HB 793. OGCSHCN hopes to use its involvement to raise general awareness of health care transition issues as well as to ensure that there are appropriate systems of primary and specialty care for CYSHCN with SCD to transition into as adults.

The OGCSHCN funded Kennedy Krieger's (KKI) Transition Lecture Series, now completing its 7th successful year. A total of 140 youth, families and providers attended eight lectures. Topics included: "Health Care Decision-Making by and for People with Intellectual and Developmental Disabilities", "Taking Care of Yourself from a Mind-Body Perspective" and by far the best attended, "Transitioning into Adulthood: The REAL Scoop!" which featured a panel of transitioning youth and their parents. Lectures are videotaped; copies are loaned to families and are available at the Regional Resource Center for Children with Special Needs on the Eastern Shore.

OGCSHCN works with the MD State Department of Education (MSDE) to disseminate the "10 Steps to Health Care Transition" tip sheet to high school students with IEPs. The Children's Medical Services Program (CMS) within OGCSHCN pays for specialty care for YSHCN enrolled in the program until the age of 22 years. Care may be covered until age 25 in some circumstances. The CMS Program staff work with YSHCN/families to assist them with transitioning into programs for adults well in advance of the time when they will lose their eligibility for the CMS program.

PPMD, partnering with the OGCSHCN, received a State Implementation Grant for Integrated Community Systems for CYSHCN. OGCSHCN staff provided leadership and staff support to develop the Maryland Community of Care (CoC) Consortium for CYSHCN. The inaugural summit was attended by over 100 physicians, other professionals, and families. Participants worked in small groups, including a group focused on CYSHCN having the necessary services to make transitions to all aspects of adult life, including adult health care, work, and independence. As a result of the Summit, MSDE is including information about health transition in the manual they developed for transitioning youth and their families and will incorporate information on health transition in their statewide transition training for youth, families, and staff. In addition, project staff were asked to and did provide presentations to a number of groups in the state including a plenary at the annual statewide transition conference.

The OGCSHCN continues its involvement with the Statewide Steering Committee on Services for

Adults with Sickle Cell Disease as a mechanism for raising awareness of health care transition issues. The Steering Committee's responsibilities include establishing institutional and community partnerships; educating the public and health care providers; and developing a comprehensive education and treatment program for adults with sickle cell disease

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Support transition clinic activities including clinics for youth with sickle cell disease and youth with diabetes | X | X | | |
| 2. Support monthly Transition Lecture Series for youth, families and providers hosted by Kennedy Krieger | | X | | |
| 3. Partner with Maryland State Department of Education to disseminate "10 Steps to Health Care Transition" education sheet to high school students with IEPs | | | X | |
| 4. Provide payment for specialty care and related services for uninsured YSHCN until age 22 years through Children's Medical Services Program | X | | | |
| 5. Support the work of the legistlatively mandated Statewide Steering Committee on Services for Adults with Sickle Cell Disease | | | | X |
| 6. Support Johns Hopkins University and University of Maryland in efforts to assess and improve health care transition services | X | X | | |
| 7. Partner with The Parents' Place of Maryland and the Center for Maternal and Child Health to gather data from Maryland families of YSHCN on parent participation in transition planning | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

OGCSHCN continued to fund transition clinics and the transition lecture series and serve on the Steering Committee for Adults with SCD. The CoC's plans for health care transition systems were again modified this year. Due to severe staff shortages in OGCSHCN, PPMD took greater responsibility for developing a Youth Advisory Council for Transition (YAC.) Plans to create the YAC with OGCSHCN fell through in FY08, so PPMD initiated a partnership with the Maryland Center for Developmental Disabilities (MCDD) and KKI for a youth transition mentoring program. This was abruptly discontinued by MCDD when the new director reviewed the activity and felt they could not continue for lack of funds, staff, and interest among youth/families. To continue to build an increased focus on the needs of YSHCN despite these developments, CoC project staff worked with the MSDE to develop training modules about transition for parents in which health transition was incorporated as a focus in one of the modules. The group that worked on these modules included parents and professionals statewide. The MSDE is currently reviewing and vetting the materials. PPMD worked with several organizations and parent groups to conduct programs for youth in transition in Baltimore City. An OGCSHCN staff person partnered with the Maryland CMCH and PPMD to develop a statewide survey of parents of CYSHCN as part of the 2010 Title V Needs Assessment. Several questions on the survey focused on youth transition to adulthood

**c. Plan for the Coming Year**

The above activities will continue. OGCSHCN is currently undergoing a reorganization. Staffing issues will continue to be a challenge in the first quarter of FY2011, as several key positions for CSHCN remain vacant.

The aforementioned parent survey for the needs assessment is complete and OGCSHCN plans to work with PPMD to prepare several issue-specific analyses of gathered data. One such issue is youth transition to adulthood. Plans for analyses include looking for patterns of responses among caregivers who report having participated in transition planning for their YSHCN versus those who report no participation. Findings will be disseminated to stakeholders through the CoC and other OGCSHCN partners.

During the 2010 Title V Needs Assessment process, youth transition to adulthood was identified as one of the state priorities for the next five years. An action plan will be developed in the coming months to identify additional transition-related activities and to create a strategic vision for the state Title V CSHCN program's role in promoting the successful transition of all YSHCN in Maryland to all aspects of adult life. The state performance measure is related to parents' participation in transition planning for their YSHCN, and a parent survey about transition will be developed by OGCHSN staff and PPMD with solicited input from the Transition Coordinator at MSDE and the Transition Specialist at KKI. PPMD will disseminate the survey each year using their extensive network of parents of YSHCN.

PPMD will conduct parent trainings during FY11 using the aforementioned materials developed in conjunction with MSDE.

The CoC will hold quarterly meetings in FY11 that focus on transition issues. The CoC will expand its transition program activities for YSHCN and their families in Baltimore City. One program serves approximately 30 youth ages 12-22 with a broad range of disabilities and SHCN who are all minority and from low income families. MCDD is partnering in six of the sessions with CoC project staff and parents from the B'More Leaders program and the MD AIDS administration is providing funding for one session. Subsequent session partners are still to be determined. Sessions are all-day trainings based on building self-advocacy skills in employment, health care, and education. Another program will focus on low income minority girls with disabilities and SHCN in Baltimore City and has a similar focus. The CoC is also exploring other opportunities to provide support and technical assistance to existing programs to enhance their capacity to provide transition information and skill building for YSHCN.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 85.1 | 81 | 83 | 86.5 | 93 |
| Annual Indicator | 80.0 | 79.9 | 92.4 | 82.6 | 82.6 |
| Numerator | 180072 | 176242 | 206988 | 183871 | 183871 |
| Denominator | 225089 | 220579 | 224013 | 222604 | 222604 |
| Data Source | | | | National Immunization Survey, Q1/2008-Q4/2008 | National Immunization Survey, Q1/2008-Q4/2008 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 83 | 83 | 83 | 83 | 83 |

**Notes - 2009**
Source: Percentage is based on data from the National Immunization Survey, Q1/2008-Q4/2008. 82.6% immunized according to 4:3:1:3:3 series. This percentage was applied to the estimated number of children between the ages of 1-3 in 2008 (denominator) based on U.S. Census Bureau Population Estimates to create a numerator. Data for 2009 is currently unavailable.

**Notes - 2008**
Source: Percentage is based on data from the National Immunization Survey, Q1/2008-Q4/2008. 82.6% immunized according to 4:3:1:3:3 series. This percentage was applied to the estimated number of children between the ages of 1-3 in 2008 (denominator) based on U.S. Census Bureau Population Estimates to create a numerator.

**Notes - 2007**
Estimated percentage is based on data from the National Immunization Survey, Q1-Q42007- 92.4% immunized according to 4:3:1:3:3 series. This percentage was applied to the estimated number of children between the ages of 1-3 in 2007(Source: Maryland Vital Statistics population estimates).

**a. Last Year's Accomplishments**
According to the Centers for Disease Control and Prevention (CDC)'s sponsored National Immunization Survey (NIS), in 2008, 82.6% of Maryland children ages 19-35 months were fully immunized as defined by the 4:3:1:3:3:1 series. This percentage is above the national average of 76%% for this time period and meets Maryland's target goal of 80% for this measure. Immunization rates for children in Baltimore City at 75% in 2008 were lower than both the State average and State average outside of Baltimore City (81%) according to the NIS.

Immunization issues were included in Maryland's Title V funded early childhood grant development activities. A priority of the Early Childhood Health Plan completed by CMCH in 2007 is to increase access to medical homes for young children. Immunizations are an important component of well child care to be promoted within the medical home. Education about the importance of immunizations as well as new Maryland vaccination guidelines are part of early childhood health outreach efforts.

The Infectious Diseases and Environmental Health Administration, Center for Immunization is largely responsible for statewide immunization activities in Maryland. Ongoing activities to promote early childhood immunization in FY 2009 included the distribution of immunization educational materials to the parents of every child born in the State, administration of the State's immunization registry, ImmuNet, and operation of the Maryland Vaccines for Children (VFC) Program.

VFC allows enrolled physicians to provide all routinely recommended vaccines, free of cost, to children 18 years old and younger who are Medicaid enrolled; uninsured; underinsured or Native American/Alaskan Native. There are currently approximately 800 enrolled providers practicing at

1,000 public and private practice vaccine delivery sites throughout the State. Immunization Excellence Awards are given to VFC providers, who demonstrate excellence in all critical areas reviewed by the VFC Program, including immunization coverage rates of two year olds; and pediatric practice standards.

ImmuNet, the State's immunization registry, began implementation in June 2004. As of May 2010, ImmuNet included 5,000,000 immunization records and was being used in more than 300 practitioner offices. The registry provides a consolidated vaccination record for children enrolled, provides reminder and recall notices, and prints forms for schools, camps, and day care.

Title V also continued to support local health department efforts to inform consumers, communities and providers about the importance of immunizations. Although the majority of children are immunized in private physician offices, several local health departments continued to offer immunization clinics serving children in underserved areas of the State in 2009. MCH nursing staff in local health departments educated families about the importance of immunizations during home visiting and early childhood programs as part of a comprehensive approach to well child care. Educational materials to promote awareness of the need for immunization continued to be a part of all MCH outreach activities. WIC Program staff determined the immunization status of their clients at every encounter.

The Maryland Partnership for Prevention (MPP), the state's immunization coalition, began offering a Practice Makes Perfect Immunization Training that provides health professionals with comprehensive resources to support promotion and administration of childhood immunizations. This half day training session provides an overview of topics that are important to safely and effectively provide immunizations, including vaccine recommendations for children, adolescents, and adults; child care and school immunization requirements; vaccine storage and handling; and the Maryland Vaccines For Children Program.

During this year, the Center for Immunization expanded ImmuNet and conducted outreach and education activities directed at both providers and families to improve immunization levels. Strategies were implemented to increase the immunization coverage rate as measured by the 4:3:1:3:3 series on the National Immunization Survey to 85% by 2020 from a baseline of 73% in 2001. Elimination of the six percentage point disparity in the vaccination rates among racial/ethnic groups was addressed. The MCH Program continued to collaborate with the Center for Immunization on these objectives.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Distribute educational materials to parents of every newborn in the state that includes information on immunizations (Center for Immunizations). | | | X | |
| 2. Fund local helath department immunization clinic and outreach/education activities. | X | | X | |
| 3. Continue to expand the state's immunization registries, Immunet (statewide) and Baltimore City registry. Title V will support the Baltimore City registry. | | X | | |
| 4. Provide insurance coverage for immunizations through Medicaid and MCHP. | | X | | |
| 5. Administer the Vacccines for Children program (Center for Immuinzations). | | | | X |
| 6. Promote immunzations through home visiting and early childhood programs. Promote acess to medical homes for all children through Early Childhood Health Grant. | | | X | |

| | | | | |
|---|---|---|---|---|
| 7. Screen for immunization status in WIC and other MCH programs. | | | X | |
| 8. Participate in MD Immunization Partnership. | | | | X |
| 9. Provide outreach and education to the general public and health care providers to improve immunization levels. | | | X | X |
| 10. | | | | |

**b. Current Activities**

The Title V Program continued to support immunization outreach and education efforts provided by local health departments. Title V funds continued to directly support Baltimore City's Immunization Registry, developed independently of ImmuNet. The City's Registry maintains a database of immunization and demographic information on Baltimore City children collected from pediatric providers. MCH staff identify children who are not up to date with their immunizations and refer them to a medical home.

Early in the 2010 fiscal year, immunization activities were heavily focused on response to the H1N1 pandemic including influenza vaccination. While not specifically related to the 4:3:1:3:3 series, strengthened partnerships and communication strategies that were developed will be used for future immunization initiatives.

**c. Plan for the Coming Year**

Activities for 2011 will include:

1. Distributing educational materials to parents of every newborn in the State that includes information on immunizations (Center for Immunizations)
2. Funding local health department immunization clinics and outreach/education activities
3. Continuing to expand the State's immunization registries, Immunet (statewide) and the Baltimore City registry. Title V supports the Baltimore City registry.
4. Providing insurance coverage for immunizations through Medicaid and MCHP.
5. Administering the Vaccines for Children Program (Center for Immunizations)
6. Promoting immunizations through home visiting and early childhood programs. Specifically work with the Maryland State Department of Education, Office of Child Care, to increase compliance with childcare immunization requirements.
7. Promoting access to medical homes for all children through the Early Childhood Health Grant.
8. Screening for immunization status in WIC and other MCH programs.
9. Participating in the state's immunization coalition, Maryland Partnership for Prevention.
10. Providing outreach and education to the general public and health care providers to improve immunization levels.
11. Conducting statewide school-based influenza vaccination clinics using American Reinvestment and Recovery Act (ARRA) funds.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | 17.9 | 17.4 | 16.4 | 16.4 | 17.5 |
| Annual Indicator | 16.8 | 17.5 | 18.3 | 17.4 | 17.4 |
| Numerator | 2047 | 2118 | 2200 | 2057 | 2057 |
| Denominator | 121697 | 121211 | 120146 | 118208 | 118208 |

| | | | | | |
|---|---|---|---|---|---|
| Data Source | | | | MD Vital Statistics, 2008; U.S. Census Bureau | MD Vital Statistics, 2008; U.S. Census Bureau |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 17 | 17 | 17 | 17 | 17 |

**Notes - 2009**
Source: Maryland Vital Statistics Administration, 2008 Annual Report; population (denominator) from U.S. Census Bureau Population Estimates. Data for 2009 is currently unavailable.

**Notes - 2007**
Source: 2006 Maryland Vital Statistics Report; Data estimated for 2007 and based on 2006 findings.

**a. Last Year's Accomplishments**
Maryland's birth rate for teens aged 15-17 years of all races dropped from 34.4 in 2007 to 32.7 births per 1000 in 2008. This is after slight fluctuations in the rate for this age group between 2005 to 2008. The rate rose from 31.8 in 2005 to 33.6 in 2006 and rose again to 34.4 in 2007 (all races). For this same time period the rate rose among black teens, going from 48.0 (2005) to 50.9 (2008) and dropped among Hispanics teens, going from 87.2 (2005) to 84.0 in 2008. The rates among these two groups remain higher than the state rate.

Teen Pregnancy prevention efforts are largely addressed and coordinated through two programs: the Maryland Family Planning Program and the Maryland Abstinence Education and Coordination Program. Presently the Abstinence Education Program is not being funded due to lack of federal funding but upon the availability of new abstinence funding through the newly established HHS Office of Adolescent Health, programs will be again be funded.

In FY 2009, the Family Planning Program served a total of 18, 459 teens ages 15-17 and 1,302 teens under the age of 15. Additionally, there was a total of 1,715 youth between the ages of 15 to 17 served in the State's three Healthy Teens and Young Adults (HTYA) sites, nearly 9% of the total teens ages 15-17. These clinics are located in Baltimore City, Prince George's County and Anne Arundel County. HTYA clinical services are offered through model clinics which embrace a comprehensive, holistic approach to health care. The program extends special services to teens and young adults who face social, cultural, institutional, and financial barriers to care. The physical and psychosocial needs of the client are equally considered. Part of this holistic approach includes information and counseling about abstinence and delaying sexual activity in addition to assuring access to contraceptives. The clinics are supported with outreach services based on a philosophy of "Reaching Out/Reaching In." Outreach staff actively reach out to young people where they live, go to school, work, and play. They reach in to young people to develop self-esteem, personal responsibility, and goals for the future.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Provide comprehensive family planning and reproductive health services to approximately 25,000 teens annually. | X | | | |
| 2. Fund 3 Healthy Teen and Young Adult programs promoting a holistic approach to teen pregnancy prevention. | X | X | | |
| 3. Upon federal release of the Federal Abstinence Education Funding, apply and administer the federal abstinence education grant. Fund abstinence education programming through grants to local health departments and other community based groups. | | X | | |
| 4. Conduct training and education events including a conference for providers, adolescents and parents/caregivers to promote abstinence and reduce teen pregnancy. | | X | | |
| 5. Collaborate with other agencies to promote positive youth development. | | | | X |
| 6. Monitor data and tends. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

With the discontinuation of federal abstinence education funding in the last fiscal year, current teen pregnancy prevention program activities have focused primarily on clinical family planning services and education. Funding has also supported teen pregnancy prevention coalition activities in two jurisdictions with high teen birth rates. The Washington County and Montgomery County teen pregnancy coalitions have conducted community activities and conferences for youth as well as trainings for professionals to educate parents on parent-child communication and connectedness strategies.

CMCH developed a matrix for prioritizing jurisdictions of greatest need for teen pregnancy prevention resources in the State. When additional federal funding becomes available via the HHS Office of Adolescent health, the plan is to potentially use this methodology to target resources. The matrix includes seven factors including teen birth rates, infant mortality rates and high school graduation rates.

**c. Plan for the Coming Year**

MCH plans for the coming year include:

. Continuing to provide family planning services and reproductive health programs directed at adolescent pregnancy prevention including Healthy Teen and Youth Adult sites;

. Working to address the increases in teen pregnancy particularly within the Latino population;

. Reviewing the state infrastructure for teen pregnancy prevention activities in Maryland and research best and promising practices nationwide.

. Monitoring and analyzing data and trends to update the state's teen pregnancy prevention plan.

Upon the availability of federal funding, restart the Maryland Abstinence Education Program and apply for federal PREP (Personal Responsibility Education Program) funding to support positive

youth development activities which focus on reducing risk behaviors including reducing teen pregnancy. Pregnancy prevention programs will focus on strengthening State collaborations, promoting greater parent/child communication, expanding programming to teens and continue to focus on the positive youth development philosophy.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 30 | 30 | 42.5 | 52 |
| Annual Indicator | 23.7 | 23.7 | 42.2 | 42.4 | 42.4 |
| Numerator | 17703 | 17703 | 25466 | 25457 | 25457 |
| Denominator | 74696 | 74696 | 60400 | 60040 | 60040 |
| Data Source | | | | Survey of Oral Health of MD School Children, 05-06 | Survey of Oral Health of MD School Children, 05-06 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 43 | 43 | 43 | 45 | 45 |

**Notes - 2009**
Source: University of Maryland Dental School, Survey of the Oral Health of Maryland School Children, 2005-2006 School Year. Data for 2009 is currently unavailable.

**Notes - 2007**
Source: University of Maryland Dental School. Survey of the Oral Health Status of Maryland School Children, 2005-2006 School Year. This is a periodic survey conducted by the University, last conducted in 2001-2002.. Based on weighted prevalence of dental sealants among MD 3rd graders during the 2005-2006 school year.

**a. Last Year's Accomplishments**
Access to oral health care is a critical problem for underserved and minority populations in Maryland. The 2005 - 2006 Survey of Oral Health Status of Maryland School Children, conducted by the University of Maryland Dental School, found that 31% of children in kindergarten and third grade had untreated tooth decay. Children residing on the Eastern Shore and in Southern Maryland had the highest rates of untreated tooth decay. Low-income, African-American and Hispanic children suffer even higher rates of tooth decay than white and upper-income children.

A 2008 Survey of Oral Health Status of Maryland's Head Start Children conducted by the University of Maryland at Baltimore Dental School, Department of Pediatric Dentistry examined three- and four-year-old children from Head Start programs across Maryland. Head Start is a

federally- funded program whose participants must be under 185 percent of the federal poverty level. All children enrolled in Head Start are to receive comprehensive health services, including medical, dental, nutrition and mental health services. In addition, since most of these children are from low-income groups, they are eligible to receive Medicaid services including EPSDT.

The study found that 35.9 percent of the 248 children examined had decayed or filled tooth surfaces (dfs), with a mean dfs of 1.68. This rate showed considerable improvement over a similar Head Start survey conducted in Maryland in 2000. However, this improvement also could be attributed to the low response rate for this survey which was only 12.5% introducing possible reporting bias. Yet, despite this limitation, this report still demonstrates high caries prevalence in a Head Start population served by a program which highly values oral health. Such high caries prevalence in three and four-year-old children is similar to other reports from Head Start children in the U.S. Children in rural areas experienced a 16 percent greater caries experience and a 27 percent greater numbers of decayed surfaces. This may be due to the fact that children living in rural areas are less likely to drink water from fluoridated community water systems when compared to children from metropolitan areas.

The Maryland Legislature continued its mandated review of utilization rates of dental health services by children enrolled in Medicaid. Inadequate access to oral health care, particularly for uninsured and Medicaid clients, continued as a concern for all areas of the State. In CY 2008, 36.7% of enrolled Medicaid children received at least one dental service. In addition, 21.3% of enrolled Medicaid children received one restorative service. This is occurring despite high rates of dental disease among children in Maryland.

Medicaid has been successful in recruiting additional participating dentists in recent years, and now 778 or 19.1% of 4,082 Maryland dentists are actively serving and billing Medicaid recipients. Further, 11.7% of all Maryland licensed dentists bill more than $10,000 per year in services to Medicaid. While more progress is clearly needed in improving access to dental care services, these statistics reflect improvement in these metrics over past years and should further increase as the oral health care reforms enacted in CY 2008 take hold.

In 2007, Secretary Colmers convened a Dental Action Committee (DAC) in response to increasing evidence of inadequate access to dental care. The DAC was charged to develop recommendations for improving access to dental services for all low income children. The Committee made 7 major recommendations (60 recommendations total) with a goal of establishing Maryland as a national model for children's oral health care. One of their recommendations was to hire a full-time state Dental Director who joined the Department of Health and Mental Hygiene in January 2008. With the strong assistance and support from federal and state legislative partners, Maryland is moving forward with the recommendations and dental reforms.

The Maryland Medicaid program carved out the dental program from the Medicaid program to contract with a single dental vendor, DentaQuest Dental Services, to administrate and oversee Medicaid dental services. The Maryland Medicaid dental program is now called Maryland Healthy Smiles and is working to reduce or eliminate many of the bureaucratic barriers that preclude dentists from participating in the Medicaid program

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Partner with the Office of Oral Health, Medicaid and other stakeholders to develop and sustain a statewide Oral Health Coalition focused on improving access to oral health care services and assisting with implementing recommendations. | | | | X |

| | | | | |
|---|---|---|---|---|
| 2. Survey preschool and school aged children to ascertain and monitor oral health status needs. | | | | X |
| 3. Fund and support a range of oral health serivces for children in local health departments including diagnostic, preventative and restorative services. Title V supports services in Baltimore City. the Office of Oral Health supports services statewid | X | X | | |
| 4. Plan and promote strategies to improve early childhood oral health. | | | | X |
| 5. Provide insurance coverage for dental health sevices for children and pregnant women through Medicaid and MCHP. | | | | X |
| 6. Administer a loan repayment program for dentists who serve low imcome populations (Office of Oral Health). | | | | X |
| 7. Fund school based dental sealant programs. | | | | X |
| 8. Promote the P.A.N.D.A. Project, a child abuse and prevention program that trains dentist to recognize abuse. | | | | X |
| 9. Disseminate a Resource Guide that identifies discounted and low cost dental health services available to eligible Marylanders. | | X | | |
| 10. Conduct astatewide pilot school sealant demonstration project in partnership with the Univeristy of MD Dental School to determine the most cost effective means to deliver sealants in school environment. | X | X | | |

**b. Current Activities**
Maryland is continuing to implement recommendations of the Dental Action Committee including:

- Enhancement of the dental public health infrastructure and increase access to dental public health services for low-income children. Funds are being used to establish new dental public health clinics and to support school-based dental programs including support for a dental wellmobile.

- Six (6) new county dental clinic programs have been established in regions of the state where there had been no dental public health program or facility. As a result of this initiative, by the end of CY 2010, residents in every Maryland jurisdiction will have access to a safety-net or school-linked dental clinic;

- The Maryland Office of Oral Health in tandem with the Maryland Healthy Smiles Program implemented a new program to enable EPSDT Medicaid medical providers such as pediatricians, family medicine physicians and nurse practitioners to be reimbursed by Medicaid for assessing and applying a preventative fluoride varnish agent to very young children not currently being seen by dentists. It has been quite successful and to date, over 5,000 medical claims have been submitted by these medical practitioners.

**c. Plan for the Coming Year**
This coming year, the MCH Program will continue:

.Working with the Office of Oral Health to implement a plan to improve the oral health of children in Maryland. Activities will include (1) working with the Maryland State Department of Education to develop a pilot project to demonstrate the effectiveness of a case management approach in integrating dental screenings into the current vision and hearing screening programs tied to school enrollment; (2) working with the Office of Oral Health and the University of Maryland at College Park, School of Public Health in developing a multi-cultural and age-specific oral health literacy campaign that reinforces the importance of oral health to the public and enhances their ability to navigate the dental care delivery system; and (3) working with the Office of Oral Health

and University of Maryland Dental School in a pilot project to demonstrate the effectiveness of a dental case management system in improving access to oral health care services for children living in an underserved region of Maryland;

.Participating in various statewide alliances and coalitions that address oral health including participation on the new statewide Maryland Dental Action Coalition;

.Assisting the Maryland Office of Oral Health in its plans to develop an online training program for EPSDT Medicaid medical providers to enable them to be reimbursed by the Medicaid Program for assessing and applying a preventative fluoride varnish agent to very young children not currently being seen by dentists;

.Working with the Office of Oral Health in its ongoing dental sealant demonstration project to assess and evaluate the most efficient and cost-effective means to develop statewide dental sealant initiatives;

.Collaborating with the Office of Oral Health in planning for the next statewide oral health survey of Maryland schoolchildren, specifically grades K and 3;

.Assisting the Office of Oral Health in developing a formal surveillance system that includes data from its PRAMS database for pregnant women;

.Working with the Office of Oral Health to develop its state oral health plan;

.Supporting local health efforts to improve access to oral health services for low-income children; and

.Reviewing oral health data for the Title V needs assessment including examining the results of an evaluation of the State's dental health infrastructure to determine additional avenues for Title V to collaborate with the Office of Oral Health to improve access to dental services for children and pregnant women.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 2.6 | 3 | 3 | 3.5 | 2.9 |
| Annual Indicator | 2.4 | 2.5 | 3.1 | 2.3 | 2.3 |
| Numerator | 28 | 28 | 34 | 25 | 25 |
| Denominator | 1153348 | 1112945 | 1107687 | 1099652 | 1099652 |
| Data Source | | | | MD Vital Statistics, 2008 | MD Vital Statistics, 2008 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 3 | 3 | 3 | 3 | 3 |

**Notes - 2009**
Data for 2009 unavailable. Estimate based on Vital Statistics 2008 data.

**a. Last Year's Accomplishments**
Injuries, including motor vehicle accidents remained the leading cause of death for children. In 2008, (the most recent year for which data is available from the Vital Statistics Administration), the death rate of Maryland Children aged 14 and younger due to motor vehicle crashes was 2.3 per 100,000. In FY 2010 the MCH Program continued to provide support and technical assistance to state and local Child Fatality Review (CFR) teams, which are legislatively mandated to review child deaths in Maryland, including those caused by motor vehicle accidents. Motor vehicle accidents are a priority concern in several jurisdictions. Each year, The Child Death Report prepared by the MCH Epidemiogist for the state CFR team identifies trends in deaths due to motor vehicle accidents.

State activities directed at preventing deaths due to motor vehicle accidents largely fall outside of the purview of the MCH Program. Maryland has enacted several strict safety belt laws. Due to an over-all highly educated population, and as a result of aggressive enforcement of these laws, Maryland has a 94% seat belt usage rate, one of the highest on the east coast. Children and young people up to 16 years of age must be secured in seat belts or child safety seats, regardless of their seating positions and may not ride in an unenclosed cargo bed of a pick-up truck. Maryland law also strictly forbids driving while impaired by alcohol or other drugs and the minimum lawful drinking age is 21 years.

Maryland law requires that, "A person transporting a child under the age of 8 years in a motor vehicle shall secure a child in a safety seat in accordance with the child safety seat and vehicle manufacturers' instructions unless the child is 4 feet, 9 inches tall or taller; or weighs more that 65 pounds". Since the 1980's, the Maryland Kids in Safety Seats (KISS) Program has been the State's lead agency for promoting child passenger safety. KISS is housed in the Family Health Administration's Center for Health Promotion and Education and funded by the Maryland Department of Transportation. Its mission is to reduce the number of childhood injuries and deaths by educating the public (e.g., 1-800 helpline, media campaigns, website) about child passenger safety including the correct use of child safety seats.

During National Child Passenger Safety Month in September 2009, jurisdictions throughout the state participated in child safety seat checks and community outreach and education activities. There were 74 child safety seat inspection events conducted in Maryland and a total of 40 presentations which reached 547 participants. Data from the National Highway Transportation Safety Association (NHTSA) indicates that the restraint use for all children from birth to 7 years was 87 percent in 2008 The average state-wide inspection misuse rate is 75 percent. The term "misuse" can range from incorrect restraint type, expired or damaged seats, loose harness, seat not installed tightly, or other minor or serious errors.

KISS continued to administer a loaner program that provided child safety restraints to over 822 low-income families in FY 2009. In addition, KISS facilitated or assisted with 17 national child passenger safety certification trainings to Marylanders including but not limited to health care/nursing personnel, fire and rescue workers, social services, foster care support staff, police cadets, law enforcement personnel, health department staff and auto dealership staff.

The Division of Injury Prevention and Health Promotion funds local injury prevention programs, several of which address motor vehicle safety. The Division has also supported the Partnership for a Safer Maryland since its inception in 2005. The Partnership brings agencies together and

focuses training and education on a variety of preventable injuries. Currently there is a sub-committee addressing MVA related issues, specifically distracted driving.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Conduct state and local child fatality review processes that include a review of deaths due to motor vehicle crashes. | | | | X |
| 2. Enforce strict Maryland child safety seat, safety belt and DUI laws. | | | | X |
| 3. Enforce laws requiring children of certain weights and at certain ages to use child passenger safety seats. | | | | X |
| 4. Educate the public about child safety seat laws and the correct use of child passenger safety seats. Administer the Kids in Safety Seats program that includes a free loaner prgoram (Office of Health Promotion). | | X | | |
| 5. Fund local injury prevention programs promoting motor vehicle safety (Family Health Administration). | | | X | |
| 6. Monitor data and trends. Publish an annual child fatality review report that includes data on deaths due to motor vehicle crashes. | | | | X |
| 7. Collaborate with other agencies and coalitions (e.g., thePartenrship for a Safer Maryland, and others) to reduce injuries. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Ongoing activities are continuing in 2010. The MCH Epidemiologist is currently completing the 2009 Annual Child Death Report. Once again, the report identifies injuries, including those due to motor vehicle accidents, as a leading cause of child deaths.

**c. Plan for the Coming Year**

In FY 2011, the State Child Fatality Review Team and the MCH Program will continue to partner with other DHMH and state agencies to reduce child deaths due to motor vehicle accidents.

MCH will continue to be represented on the Partnership for a Safer Maryland in its efforts to advocate for injury and violence prevention. Addressing childhood deaths and injuries due to motor vehicle accidents is one important part of the Coalition's goals.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | | 42 | 44 | 41 | 44 |
| Annual Indicator | 40.8 | 40.2 | 43.0 | 43.0 | 43.0 |
| Numerator | 29085 | 31127 | 33565 | 31860 | 31860 |
| Denominator | 71286 | 77430 | 78057 | 74094 | 74094 |
| Data Source | | | | NIS, 2006 and 2006 Vital Statistics Infant Data | NIS, 2006 and 2006 Vital Statistics Infant Data |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 44 | 44 | 44 | 44 | 44 |

**Notes - 2009**
Source: 2009 data is currently unavailable; Data on percentage of infants breastfeeding at 6 months is from the National Immunization Survey of the CDC, 2006. This percentage was applied to the infant population (denominator) in Maryland in 2006 to produce an estimated numerator.

**Notes - 2008**
Source: 2008 data is currently unavailable; Data on percentage of infants breastfeeding at 6 months is from the National Immunization Survey of the CDC, 2006. This percentage was applied to the infant population (denominator) in Maryland in 2006 to produce an estimated numerator.

**Notes - 2007**
Source: National Immunization Survey. Breastfeeding rates for Maryland children born in 2004. Indicates that an estimated 40.2% of Maryland women were breastfeeding at 6 months. This percentage was applied to the number of births in Maryland in 2006. Data for 2007 is currently unavailable.

**a. Last Year's Accomplishments**
The Title V Program supported the Maryland Breastfeeding Coalition through much of FY 2009. In April 2009, the Coalition became an independent group, with Title V no longer providing leadership and staffing support. Title V continued to maintain a breastfeeding support website at www.marylandbreastfeeding.org with resources for women, health professionals, and employers. The statewide Breastfeeding-Friendly Workplace Initiative, launched in February 2008, continued to expand. A first round of "Breastfeeding-Friendly Workplace Awards", sponsored by Title V and the Maryland Dept. of Health and Mental Hygiene, were awarded in August 2009, during International Breastfeeding Week. Breastfeeding promotion continued in Title V funded Improved Pregnancy Outcome Programs in every jurisdiction in the state. Lactation support in all Maryland birthing hospitals was reaffirmed in the October 2008 update of the Maryland Perinatal System Standards.

The WIC Program continued to promote breastfeeding as the preferred method of infant feeding for all clients. WIC maintained a Breastfeeding Coordinator and all WIC staff have received training in advanced lactation support. WIC continued its Peer Counseling Breastfeeding Support

Program in several Maryland counties.

The CDC National Immunization Survey for births in 2006 shows 76.4% of Maryland mothers initiating breastfeeding, 43.3% breastfeeding at 6 months (10.1% exclusively) and 25.4% breastfeeding at 12 months. With the exception of exclusive breastfeeding at 6 months, these percentages are all at or slightly above the national averages. Maryland now ranks 23rd among the 50 states and the District of Columbia for the percent of mothers who ever breastfed, 27th for mothers breastfeeding at 6 months, and 18th for mothers breastfeeding at 12 months.

Nationwide, the CDC reports continued racial disparity in breastfeeding rates. For 2006 births, nationally 56.5% of non-Hispanic Black, 73.8% of non-Hispanic white, and 82.1% of Hispanic mothers reported ever breastfeeding. Maryland PRAMS data for 2006 births show less racial disparity in breastfeeding rates in Maryland with 76.4% of non-Hispanic Black, 77.7% of non-Hispanic white, and 96.2% of Hispanic mothers ever breastfeeding.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Disseminate breastfeeding support materials and provide technical assistance for employers to promote breastfeeding supprt in the workplace, as now mandated by federal health care reform legislation. | | | | X |
| 2. Redesign the "Breastfeeding-Friendly Workplace award" to recognize exemplary support programs and progams maintaned by small businesses (less than 50 employees). | | | | X |
| 3. Educate the public about the passage of "right to breastfeed" legislation in Maryland. | | | X | |
| 4. Fund and support breastfeeding promotion activities in local health departments. | | | | X |
| 5. Educate health care providers about the benefits of breastfeeding and encourage health providers to promote breastfeeding. | | | X | |
| 6. Maintain standards for lactation support in all Maryland's birthing hospitals. | | | | X |
| 7. Update and maintain the Maryland breastfeeding website. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Title V continues to maintain a breastfeeding support website at www.marylandbreastfeeding.org with resources for women, health professionals, and employers. With the passage this year of federal Health Care Reform legislation requiring businesses to provide breastfeeding support for lactating women in the workplace, Title V is transitioning its Maryland Breastfeeding-Friendly Workplace Initiative from recruiting businesses to provide lactation support to providing resources and technical assistance to help businesses meet the federal requirements. Plans are underway to redesign the "Breastfeeding-Friendly Workplace Award," sponsored by Title V and the Maryland Dept. of Health and Mental Hygiene, to recognize exemplary workplace support programs and programs maintained by small businesses (<50 employees) that could seek exemption from the federal requirements.

Breastfeeding continues to be promoted in Title V funded Improved Pregnancy Outcome Programs in every jurisdiction in the state. Lactation support in all Maryland birthing hospitals

remains a part of the Maryland Perinatal System Standards. The WIC Program also continues to promote breastfeeding as the preferred method of infant feeding for all clients, and maintains a Breastfeeding Coordinator, training in advanced lactation support for all WIC staff, and its Peer Counseling Breastfeeding Support Program in several Maryland counties.

**c. Plan for the Coming Year**

During the coming year, the Title V Program plans to continue its ongoing activities that support breastfeeding as the norm for infant feeding in Maryland. Plans for FY 2011 include:

. Outreach to businesses in the State, including State agencies, with resource materials and technical assistance to help them meet the federal Health Care Reform requirements to support lactating women in the workplace.

. Showcase outstanding workplace lactation support programs by recognizing them with the Maryland Breastfeeding-Friendly Workplace Award.

. Maintain and expand the Maryland Breastfeeding website.

. Expand awareness in the state of the Maryland law protecting the right to breastfeed.

. Provide outreach and technical assistance to local health departments and other state agencies to implement breastfeeding promotion activities appropriate to their area of responsibility.

. Continue to educate health care providers about the benefits of breastfeeding and encourage their promotion of breastfeeding.

. Expand community outreach activities to increase the number of Maryland mothers, of all racial and ethnic groups, who not only initiate breastfeeding but continue breastfeeding for at least 6 months. Examples include activities at health fairs, community events, ethnic street fairs, faith-based organizations, etc.

. Continue to identify other funding sources to address breastfeeding promotion activities.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 90 | 98 |
| Annual Indicator | 88.5 | 89.4 | 92.5 | 98.8 | 98.7 |
| Numerator | 62870 | 64657 | 68622 | 74276 | 70984 |
| Denominator | 71013 | 72345 | 74196 | 75210 | 71917 |
| Data Source | | | | State IH System | State IH System |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2009**

Number of occurrent births is from MD Vital Statistics and is only provisional at this time. The screening data is primarily from the old state IH system because the new OZ eSP system was not in place for the full year.

While we would like to maintain our progress in screening an increasing percentage of babies before hospital discharge, our historical struggles with databases and providers, make us wary of setting 100% as the measure for satisfactory performance. It may not be realistic.

**Notes - 2008**
Number of occurrent births is from MD Vital Statistics and is only provisional at this time. The screening data is primarily from the old state IH system because the new OZ eSP system was not in place for the full year.

While we would like to maintain our progress in screening an increasing percentage of babies before hospital discharge, our historical struggles with databases and providers, make us wary of setting 100% as the measure for satisfactory performance. It may not be realistic.

**a. Last Year's Accomplishments**
Of the 2009 MD birth population, it was reported to the Infant Hearing Program that 71, 917 newborns needed hearing screening (birth population minus deaths, moved out of state, refused, and terminated further hearing care). 99% (70,984) of those babies underwent newborn hearing screening and nearly all of them had their screenings before they were 1 month of age. The average age for follow up hearing screening was 25 days. The screening rate from the first half of the year to the second increased from 98.8% to 99.2% indicating that we have nearly achieved our goal of meeting the first milestone of the 1-3-6 EHDI goals of screening all newborns before one month of age. 93.6% of the babies screened in the birth hospitals passed their screening, and 3.9% referred. A total of 4,603 babies needed outpatient hearing screening due to screening refers or missing the inpatient hearing screening.

A total of 3,108 outpatient hearing screenings were performed on babies born in 2009. Of the 1,749 babies that missed their inpatient hearing screening, 58.5% (1024) of that population returned for an outpatient hearing screening, and 73% (2,084) of the 2,854 babies that failed their inpatient newborn hearing screening returned for an outpatient hearing screening. Of the babies that returned for an outpatient hearing screening, 217 (8.7%) required diagnostic follow up testing.
A total of 82 babies, (0.2% of the birth population), were identified with hearing loss; however, another 88 babies were identified as being ‘not yet determined' indicating that the degree and/or type of hearing loss had not yet been determined. Therefore, it is likely that another 170 babies have hearing loss. The average age of identification of hearing loss was 4 months which is an improvement of nearly 2 months from the previous year.

Additionally, the Infant Hearing Program was able to secure funding and execute a contract modification with our current data base vendor, OZ Systems. The contract will include upgrades to the existing system that will enhance current functionality and userability, as well as incorporate a new module for early intervention tracking. An MOU between the Department of Health and Mental Hygiene and the Maryland State will allow data sharing between agencies on infants identified with hearing loss.
Review of 2009 compliance reports revealed significant improvement in all areas, particularly in the percent of NICU babies in process. This improvement is especially significant because it shows a marked improvement in the reporting of NICU babies hearing screening rates which has long been suspected as a major contributing factor in Maryland's lost to follow up. By having numbers and compliance rankings go out to the nurse managers every month they are able to see some of their program deficiencies and work to rectify them. As a result of these interventions, compliance with the NICU metric improved 10 fold and the identification of pediatricians improved 15%. Coupled with efforts made to the hospitals by providing them with quantitative feedback, hospitals and outpatient providers have improved their reporting of screening results which has in turn improved the Infant Hearing Program's ability to follow up on infants that missed or referred on their inpatient hearing screening. The combined inpatient and

outpatient screening rate for 2009 was 99%.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Support hearing screening for all Maryland newborns. | X | | X | |
| 2. Provide tracking and follow-up on all screening referrals and not tested infants to confirm hearing status. | | X | X | |
| 3. Education materials regaridng hearing screening for parents, families and providers developed and available. | | X | X | X |
| 4. Education materials developed and available for parents regarding hearing evaluation and developmental milestones in multiple languages for provider use. | | X | X | X |
| 5. Enhance the program website to include educational brochures and reporting forms in downloadable format for providers and families. | | X | X | X |
| 6. Continue training in an on-going manner for birthing faciltiies and audiologists/other providers entering patient data in the web based eSP system. | X | X | X | X |
| 7. Birthing faciltiies provided with site evaluations. | X | X | X | X |
| 8. Continue the enhancement of the eSP database to add additoinal features. | X | X | X | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Improve data management: Results are now available in real time, so Infant Hearing Program staff is able to monitor hospitals' daily screening process' and identify problems before they become systemic. Increase result reporting, decrease reporting errors, and improve timeliness of test results availability: To be certain that all births are being entered into eSP, hospitals not doing direct importing are required to forward daily census to the Infant Hearing Program for manual review of those sites to ensure that no baby escaped being entered into the system. Identify factors influencing loss to follow up: Monthly compliance reports are compiled/shared with each hospital. Reports provide numbers/percentages and scores on predetermined metrics. Hospitals are given scores of meeting compliance, distinguished compliance or non-compliance. Decrease the number of rescreen failures who do not receive timely diagnostic audiologic assessments: Efforts are underway with DHMH legislative office and Universal Newborn Hearing Screening Advisory Council to introduce legislation to update the current law, strengthen data sharing, and mandate reporting of diagnostic results. Increase the number of children diagnosed as deaf or hard of hearing into appropriate, culturally sensitive early intervention by 6 months of age. An MOU has been developed between DHMH and MSDE. Funding has been secured and plans made to add an early intervention module to the existing online data system.

**c. Plan for the Coming Year**

MD EHDI has elected to focus intense efforts on the technical aspects of hearing screening tracking and surveillance. The addition of the online data management system, while an expensive, time consuming project, has already proven to have numerous benefits. However, there are limitations to the data base and the Infant Hearing Program has received a grant to upgrade and enhance the current online data system. Funding will be used to configure an early intervention module of eSP in order to track and monitor referral and enrollment status of children with hearing loss in the state of Maryland. An aggregate reporting feature to the EI module will be programmed to allow users to see how many referrals and enrollments are present and/or

needed. The second report to be added is an aging report to provide analysis of the age at which referrals and enrollments were provided to children in Maryland. Programming enhancements will be made to improve the tracking of at risk infants, reducing duplications, and logic changes that will improve statistical analysis.

Unmet need continues to be the availability of diagnostic pediatric facilities. Parts of the state have no audiology referral sites and parents are forced to bring their babies to the larger urban centers such as Baltimore and Washington D.C.. Remote auditory brainstem response testing appears to be the best solution, an ABR unit would be
rotated to the various areas of the state that are not served and testing would be completed by an audiologist in a distant urban center via telehealth networks. However, the practical aspects of funding and initiating this type of technical, as well as service, program are significant. Funding for expensive items such as an ABR unit may be available, but even if the funds are available, procurement procedures in Maryland and the Department of Health and Mental Hygiene are so protracted that expending the funds within the grant period is nearly impossible. Still, the Infant Hearing Program administrators are committed to this goal, and efforts will be made to make this type of program a reality.

Currently, there are no direct links between the eSP data base and other State health departments data bases, even though this type of linkage would prove invaluable both in coordination of follow up and evaluation of prevalence and incidence, socio-economic and demographic impacts, service delivery needs, and care coordination. Development and integration of databases occurs in isolation which makes after-the-fact data sharing linkage costly and labor intensive. However, plans are being formulated to develop file sharing relationships with Vital Statistics Administration, and the Maryland State Department of Education Infants and Toddler Program.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 9.5 | 9.6 | 9.6 | 12.1 | 10 |
| Annual Indicator | 9.6 | 12.0 | 12.0 | 10.0 | 10.0 |
| Numerator | 133902 | 163264 | 163264 | 136300 | 136300 |
| Denominator | 1394808 | 1360531 | 1360531 | 1363004 | 1363004 |
| Data Source | | | | U.S. Census Bureau, CPS, 2008-2009 | U.S. Census Bureau, CPS, 2008-2009 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 11 | 11 | 11 | 11 | 11 |

**Notes - 2009**
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008-2009 (2-year average of data collected in 2008 and 2009). Children defined as under 18 years.

**Notes - 2008**
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008-2009 (2-year average of data collected in 2008 and 2009). Children defined as under age 18 years.

**Notes - 2007**
Source: Maryland Health Care Commission, Maryland Health Insurance Coverage in 2005-2006, issued November 2007. Estimates that 12% of children under the age of 19 in Maryland are were uninsured. Based on findings frm the March 2007 Bureau of the Census revised Current Population Survey estimates. Estimate based on 2005-2006 findings since data for 2007 is currently unavailable.

**a. Last Year's Accomplishments**
An estimated 760,000 (15.4%) Marylanders under the age of 65 lacked health insurance coverage in 2006-2007 according to a Maryland Health Care Commission report based on data from the Census Bureau's Current Population Survey. Approximately 20% of the State's uninsured were children under of the age of 19 .Medicaid and MCHP are partially credited with a Maryland trend towards decreasing numbers of uninsured children. Among racial/ethnic groups, the uninsured rate is highest in Hispanics.

Medical Assistance and the Maryland Children's Health Insurance Program (MCHP) continued to provide health insurance coverage for low income children. MCHP, which is administered by the Medicaid Program, provided access to health insurance coverage for significant numbers of uninsured Maryland children in families with incomes up to 400% of the poverty level. MCHP Premium serves children in families with incomes between 200% and 300% of the federal poverty level. Enrolled families pay a monthly contribution. During federal fiscal year 2005, enrollment in MCHP exceeded 130,000 while Medicaid provided coverage to 404,146 children.

The Children's Medical Services Program within the OGCSHCN provides coverage for specialty care for uninsured and underinsured CSHCN in family incomes below 200% of the federal poverty level. Since Medical Assistance also covers this same income group, most of the children served are undocumented.

The MCH Hotline (1-800-456-8900) refers families to local health departments to receive assistance in determining their eligibility for Medicaid and MCHP programs. During Child Health Month and other special observances, the CMCH Outreach Coordinator works closely with local health agencies to distribute pamphlets and other materials that promote Medicaid and MCHP. Resource guides, brochures and fact sheets are periodically distributed by CMCH at health fairs and community events.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Refer families to Medicaid and medical services through the MCH hotline. | | X | | |
| 2. Provide health insurance coverage for eligible low income children in families with incomes to 250% of FPL through | | X | | |

| | | | | |
|---|---|---|---|---|
| Medicaid and MCHP. | | | | |
| 3. Provide coverage for eligible CYSHCN through the Office of Genetics and Children with Special Health Care Needs. | | X | | |
| 4. Provide outreach to enroll eligible children into Medicaid and MCHP. Disseminate resource information including sources of financial assitance for health care at health/community health fairs and other outreach events (MCH staff in local health depar | | X | | |
| 5. Assess health needs and issues confronting uninsured children and families including geographic and racial/ethnic disparities. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

In FY 2010, State and local MCH programs continued to support the Medicaid Program in enrolling eligible children and adolescents. Outreach strategies will include distributing MCHP/Medicaid eligibility information to schools, licensed day care centers, Head Start programs, and at community events and health fairs. As funding allows, periodic media campaigns will be used to promote the MCH Information and Referral Hotline. The MCH Hotline will continue to refer pregnant women and families to local health departments and other program sites that determine eligibility for Medical Assistance Programs.

**c. Plan for the Coming Year**

Reforming the health care system to reduce the numbers of uninsured in Maryland continues to be a priority of the new Health Secretary. The 2010 MCH needs assessment identified key priorities including uninsured children and families in Maryland and assessing the State's capacity to reduce the numbers of uninsured children and women of childbearing age.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 32.5 | 32.5 | 32.5 | 32 |
| Annual Indicator | 33.0 | 33.0 | 33.0 | 33.1 | 33.2 |
| Numerator | 10944 | 10944 | 11881 | 14326 | 16302 |
| Denominator | 33164 | 33164 | 36002 | 43317 | 49065 |
| Data Source | | | | WIC Program Data for 2008 | WIC Program Data for 2009 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 33 | 33 | 33 | 32 | 31 |

**Notes - 2009**
Source: WIC Program data, 2008
Data for 2009 is currently unavailable.

**Notes - 2008**
Source: Maryland WIC Program data; Maryland WIC estimates for 2008 based on enrollment and BMI analysis for the period, July-December 2008.

**Notes - 2007**
Source: Maryland WIC Program data.Maryland WIC estimates for 2007 based on enrollment and BMI analysis for the period, July-December 2007.

**a. Last Year's Accomplishments**
WIC program data continues to be the primary source for overweight and obesity data for children younger than five years of age. WIC Program data for 2009 indicates that one in three two to five years old WIC enrollees were overweight and/or obese. In 2008, the prevalence of obesity in Hispanic children 2-5 years (23.9%) was higher than that of whites (13.9%) and African Americans (12.2%). Maryland prevalence rates are higher than national prevalence rates among 2-5 year old WIC enrollees. The 2008 national prevalence of overweight and obesity 31.3%.

Surveillance data on overweight and obesity among Maryland children and adolescents is limited, but improving. Data sources continue to include the 2007 Maryland Youth Risk Behavior Survey (2005 -- 2009),, the 2006 Maryland Youth Tobacco survey, BMI data collected by the WIC Program through the Maryland Pediatric Nutrition Surveillance System, and Medicaid data collected from chart reviews. The 2007 National Survey of Children's Health provides statewide estimates of the percentage of children, ages 10-17, overweight or obese. An estimated 13.3% were overweight (obese according to current terminology) and another 16.6% were at risk for being overweight (overweight according to current terminology). Black (42%) and Hispanic (32%) children were more likely than White (24%) children to be overweight/obese.

Among the most recent significant accomplishments has been the engagement of policymakers and other key stakeholders in recognizing obesity as a significant issue in childhood. In 2008, House Bill 1176 established a statewide Committee on Childhood Obesity. The Committee submitted a report identifying recommendations for immediate action to the Governor and Maryland General Assembly in December 2009. This report contained 12 priorities related to: (1) insurance reimbursements paid to health care providers to diagnose and treat childhood obesity; (2) a system for collecting, analyzing, and maintaining Statewide data relating to childhood obesity; (3) best and promising practices to address childhood obesity, including community and school-based approaches; (4) methods to enhance public awareness of the chronic diseases related to childhood obesity, including the increased number of children developing diabetes; and (5) methods to increase the rate of obesity screenings for children.

Additional recent accomplishments include the completion of statewide surveillance initiatives among Medicaid EPSDT enrollees and Maryland physicians who perform well child visits. The data analysis project, "Childhood Overweight and Obesity Surveillance Among Medicaid EPSDT Enrollees" was completed by Dr. De Pinto and Lee Hurt, MCH epidemiologist, in collaboration with the Medicaid EPSDT Program. The success of this project has resulted in a strengthened collaborative relationship with Medicaid and has set the foundation for childhood obesity surveillance activities among Medicaid enrollees. Dr. De Pinto and Ms. Hurt presented the study results to MCO medical directors, Local Health Officers, and the Childhood Obesity Committee and conducted CME grand rounds presentations. The results of the study showed that a

significant proportion of overweight and obese participants are not diagnosed; and many obese participants are not appropriately screened for complications, but of those screened, a significant proportion have an obesity related complication.

This ongoing study identified BMI among a cross-sectional sample of children enrolled in Medicaid, and it is an important contribution to Statewide data collection regarding overweight and obesity prevalence among Maryland children.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Collaborate withthe Office of Chronic Disease Prevention (OCDP), WIC and others to plan and implement strategies to reduce childhood overweight and obesity. | | | | X |
| 2. Implement child and adolescent health components of the state's most recent Physical Activity Plan. | | | | X |
| 3. Work with the MD AAP, Medicaid and others to improve surveillance. | | | | X |
| 4. Promote awareness of childhood overweight and obesity among health prtoviders, families and the general public through presentations, funding of pilot programs and conducting education sessions. | | | X | |
| 5. Support implementation of referral networks and otehr services for children who are overweight or obese. | | | | X |
| 6. Collaborative efforts with the OCDP to develop policy recommnedations for reimbursement for obesity risk assessment, prevention and treatment. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Childhood overweight/obesity was identified as a priority issue both in the 2005 and 2010 MCH needs assessment. The Office of Chronic Disease Prevention (OCDP) has lead responsibility for addressing overweight/obesity in Maryland. CMCH continues to collaborate with OCDP to address childhood obesity through strategic planning, surveillance, provider education, research translation, and public awareness initiatives. Dr. Cheryl De Pinto leads childhood obesity prevention activities for CMCH and serves on the American Academy of Pediatrics, Maryland Chapter, Childhood Obesity Committee, which partners with CMCH and the OCDP on obesity prevention strategies, outreach, and education. Additionally, she serves as the liaison to OCDP in implementing the Maryland Nutrition and Physical Activity Plan. This plan includes objectives related to active community environments; business and industry; families and communities; healthcare, and schools. Specific plan objectives include increasing breastfeeding rates, increasing student physical activity, increasing fruit and vegetable consumption among students; and improving surveillance systems.

**c. Plan for the Coming Year**

During 2011, Maryland will continue to promote healthier environments for preschool age children. Multiple stakeholders including MSDE, DHMH, and the Maryland AAP are collaborating

to develop a preschool wellness policy, which will include strengthening childcare licensing standards related to nutrition, physical activity, and time spent in front of a tv screen.

House Bill 1017/Senate Bill 700--Health Insurance--Child Wellness Benefits was signed into law following the 2010 legislative session. This bill mandates both public and private insurance coverage for obesity evaluation and treatment management. CMCH and OCDP will monitor this law's impact on childhood obesity evaluation and treatment and disseminate information about this policy to appropriate stakeholders.

In addition, the Maryland Health Quality and Cost Council, which is chaired by the Lt. Governor and co-chaired by the Secretary of Health, has a Wellness and Prevention workgroup which has prioritized childhood obesity. As part of the Governor's health reform initiatives, the Health Quality and Cost Council is charged with identifying actionable strategies to create a culture of wellness in Maryland communities. Strategies under consideration include promoting worksite wellness to enhance the health of parents who are role models for their children's behavior, a campaign to promote the availability of data-driven, evidence-based childhood obesity programs through non-profit hospitals' community benefits, and enhancing access to childhood obesity treatment through third-party reimbursement or convergence grants.

The Council will also champion recommendations of other State agencies and Councils that are working to increase access to healthy food and opportunities for physical activity in communities and schools. This Council recently launched the Healthiest Maryland campaign, which is a movement to create a culture of wellness--an environment that makes the healthiest choice an easy choice. Healthiest Maryland includes a focus on the school sector by building on the Maryland State Department of Education's initiative to facilitate the implementation and monitoring of local school system wellness policies and recognizing schools that implement exemplary practices.

CMCH and the OCDP will continue to collaborate with the Maryland State Department of Education on implementation and evaluation of wellness policies, and school-based surveillance recommendations.

CMCH and OCDP will continue to collaborate to promote the implementation of the Committee on Childhood Obesity's recommendations and involve relevant organizations including the Maryland Healthy Eating and Active Lifestyle Coalition. OCDP is supporting two demonstration projects to implement proven, multi-level interventions (Shape Up Somerville and We Can) in two Maryland counties. In addition, OCDP provides technical assistance for childhood obesity interventions in Baltimore City.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 10.9 | 10.7 | 7.6 | 9 |
| Annual Indicator | 11.1 | 7.8 | 9.3 | 10.9 | 10.9 |
| Numerator | 8270 | 6040 | 6160 | 7357 | 7357 |
| Denominator | 74500 | 77430 | 66425 | 67625 | 67625 |
| Data Source | | | | MD PRAMS 2008 | MD PRAMS 2008 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 11 | 11 | 11 | 11 | 11 |

**Notes - 2009**
Source: Maryland PRAMS 2008; Data for 2009 currently unavailable.

**Notes - 2008**
Source: Maryland PRAMS 2008

**Notes - 2007**
Numerator, denominator, and percentage estimates based on MD PRAMS

**a. Last Year's Accomplishments**
Data from the 2008 Maryland Pregnancy Risk Assessment Monitoring System (PRAMS) survey indicates that 10.9% of women surveyed reported smoking during the last 3 months of pregnancy. Smoking was most prevalent among White non-Hispanic and younger mothers. Among mothers over the age of 19, those with more than a 12th grade education were much less likely to smoke (4.4%) than those with a 12th grade education (18.7%) or less (24.7%). Smoking during late pregnancy also varied by Medicaid status, with 15% of women on Medicaid smoking compared to 6% of privately insured women.

Data from the Maryland Prenatal Risk Assessment Dataset indicate that low-income pregnant women were more likely than pregnant women in the general population to smoke prenatally. This database reported that 21.1% of the 18,140 pregnant women referred to local health departments through the Prenatal Risk Assessment process were tobacco users in FY 2009. (The Prenatal Risk Assessment Form is completed by health providers serving predominantly Medical Assistance and low income women in the State. The database included approximately 23% of the State's pregnant women in 2009).

The Maryland Center for Health Promotion and Education is the lead agency responsible for smoking cessation activities in DHMH. This Center administers three smoking cessation programs that include a focus on pregnant women: (1) the Smoking Cessation in Pregnancy (SCIP) Program; (2) a statewide toll-free telephone quitline that delivers cessation counseling services without charge (Quitline); and (3) in-person smoking cessation counseling conducted through local health departments outside the SCIP program (LHD-C Program).

SCIP Program- SCIP is a multi-component program that trains local health department and Medicaid managed care staff to facilitate smoking cessation among pregnant women and women considering pregnancy. Female smokers meet with public health nurses who counsel them to quit or reduce tobacco use. Along with one-on-one counseling, participants receive self-help materials in the form of a manual and a "Quit Kit." In FY 2009, approximately 750 Quit kits and 1,435 brochures were distributed, as well as over 777 other promotional items for the public. The Center updated its SCIP Booklet in Early 2008 to reflect more current data and information.

Quitline- The statewide quitline (1-800-QUIT-NOW) provides cessation counseling by ‘Free & Clear' tailored to the individual needs of callers, including pregnant women. During Fiscal Year 2009, the quitline served 51 pregnant women, 57 women planning to become pregnant during the next 3 months, and 10 women then currently breast feeding..

LHD-C Program- During FY 2009, local health departments provided smoking cessation services to 367 pregnant women. These services included promoting smoking cessation during pregnancy

as a part of preconception health counseling during family planning clinic visits. Some clinics supplied nicotine patches and/or Zyban to clients. Educational materials promoting smoking cessation were also offered during home visits and at health fairs and other educational events. Local health departments continued to partner with groups such as the March of Dimes to educate pregnant women about the health risks linked to smoking during pregnancy.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Monitor trends in smoking rates during pregnancy using several data sources including PRAMS and birth records. | | | | X |
| 2. Promote smoking sessation during preconception health counseling in family planning clinics, during local health deparment prenatal care clinic visits and during prenatal and post partum home visits. | | X | | |
| 3. Refer women of child bearing age who smoke to smoking cessation programs including the Smoking Cessation in Pregnancy (SCIP) administed by the Office of Health Promotion. | | X | | |
| 4. Promote smoking cessation in schools. | | | X | |
| 5. Enforce MD laws enacted to eliminate smoking in schools. | | | | X |
| 6. Support enforcement of Maryland's statewide Clean Indoor Air legislation that prohibits smoking in all indoor worksites including restaurants and bars. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

CMCH continues to collaborate with multiple intra and inter-agency groups include the Center for Health Promotion, the American Lung Association, private providers, community-based organizations and the American College of Obstetricians and Gynecologists to promote strategies to reduce smoking during pregnancy. CMCH used the PRAMS dataset to complete additional analyses on smoking during pregnancy. The analysis showed smoking prevalence was significantly higher among mothers with a delivery paid by Medicaid compared to those with private insurance (14% vs. 7%). Smoking prevalence was especially high among White non-Hispanics with a Medicaid delivery (33%). Delayed initiation of prenatal care and inadequate consumption of preconception vitamin supplements are also associated with smoking. Smokers are significantly more likely to report an unintended pregnancy than nonsmokers. Smokers (especially Black non-Hispanic, heavier smokers) are also significantly more likely to report experiencing such stressful life events as homelessness and physical fights with a partner than nonsmokers. Additional analysis showed that heavier postpartum smokers were significantly more likely to report symptoms of postpartum depression than nonsmokers (28% vs. 13%). These women reported often or always feeling down, depressed, hopeless, or having little interest or pleasure in doing things. Black non-Hispanic heavier smokers reported the highest prevalence of PP depression symptoms at 36%.

**c. Plan for the Coming Year**

In 2011, CMCH plans to use the PRAMS dataset to continue assessing prenatal use of tobacco. In addition, pilot programs will be implemented in three family planning clinics to enhance smoking cessation referrals.

In the fall of 2010, the Center for Health Promotion will conduct a statewide tobacco use survey to track smoking patterns among adolescents attending Maryland middle and high schools. A previously planned tobacco survey of Maryland adults was cancelled due to funding issues.

Additionally, the SCIP Program will continue to distribute self-help materials in the form of a manual and a "Quit Kit," the Quitline will continue to provide cessation counseling and its' own "Quit Kit" to pregnant callers, and the LHD-C programs will continue to provide in-person cessation counseling to pregnant women who fall outside of the SCIP framework.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 5.9 | 4.7 | 4.6 | 4.1 | 6.6 |
| Annual Indicator | 6.2 | 4.2 | 6.6 | 4.7 | 4.7 |
| Numerator | 25 | 17 | 27 | 19 | 19 |
| Denominator | 405382 | 406425 | 408340 | 407227 | 407227 |
| Data Source | | | | MD Vital Statistics Annual Report 2008 | MD Vital Statistics, 2008 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 5 | 5 | 5 | 5 | 5 |

**Notes - 2009**
Source: MD Vital Statistics Annual Report, 2008; 2009 data is currently unavailable.

**Notes - 2008**
Source: MD Vital Statistics Annual Report, 2008

**Notes - 2007**
Estimate based on 2006 data. Data for 2007 is currently unavailable.

**a. Last Year's Accomplishments**
Suicide and homicide are leading causes of deaths among adolescents in Maryland. The rate (per 100,000) of suicide deaths among youths aged 15 through 19 was 4.7 in 2008.

The Maryland Mental Hygiene Administration (MHA) has lead responsibility for administering programs to prevent adolescent suicide among youth and young adults ages 15-24. Maryland is nationally recognized as a leader in reducing adolescent suicide rates among this age group. For the past 14 years, October has been proclaimed as Youth Suicide Prevention Month in Maryland and MHA sponsors an annual conference on suicide prevention. Funds are also awarded to local

school districts to sponsor educational events. A full time Youth Suicide Prevention Coordinator supports these activities.

Maryland was the first State in the nation to offer a toll free decentralized Youth Crisis hotline service to address the needs of troubled youth. The 24-hour toll free Youth Crisis Hotline (1-800-422-0008) is staffed by trained counselors and uses a decentralized system which enables the counselor to access or refer the youth to local agencies for assistance. Throughout its 17 year history, the hotline has been very successful in intervening with youth considering suicide.

In October 2008 Maryland was awarded 1.5 million dollars from the Garrett Lee Smith Youth Suicide Prevention Grant and monies were awarded to local jurisdictions in 2009. This substantial funding focused on reaching young people through schools and community based projects in many areas, especially in high risk areas. Level One funding for School Programs was awarded to 17 school districts. Level Two funding for High Risk Counties was awarded to 3 counties, while Level Three funding for Community Based Projects was awarded to 2 counties.

The Youth Risk Behavior Survey (YRBS) 2009 data, helped to define the magnitude of depression and suicide among adolescents in Maryland. These data indicated that:
•26% of high school students reported feeling sad or hopeless, a proxy measure for depression. Rates were higher for females (33%) than males (19.1%).
• 13.8% reported seriously considering suicide, while 10.9% indicated making a suicide plan.
•6.3% reported attempting suicide with females (8.1%) more likely than males, (4.6%), to report an attempt.
•1.9% reported requiring medical attention following a suicide attempt.

In July 2009, the MCH Program sponsored a half day session on youth suicide intervention in the school setting, as part of the State's annual four day School Health Interdisciplinary Program (SHIP) conference. This session provided participants with a greater understanding of the stresses experienced by school aged children that too often lead to suicidal thinking. The session covered intervention strategies that schools can adopt to meet the growing academic demands and mental health needs of children. There will be a similar session at the 2010 SHIP conference. Title V was represented on an MHA Committee that completed the State Suicide Prevention Plan.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Conduct state and local child fatality review processes that include suicide prevention. | | | | X |
| 2. Co-sponsor and participate in planning for the annual statewide youth suicide prevention conference. | | | | X |
| 3. Work with the Mental Hygiene Administration's (MHA) Youth Suicide Prevention Program to implement the statewide plan and promote school-based activities. | | | | X |
| 4. Administer a statewide Youth Crisis Hotline (MHA). | | X | | |
| 5. Collaborate with other stakeholders to promote positive youth development through initaitives such as Ready by 21. | | | | X |
| 6. Assess and monitor data on youth suicide and related factors. | | | | X |
| 7. Participate in the grant reveiw and awards process from the Garrett Lee Smith Youth Suicide Prevention grant. | | | | X |
| 8. Participate in the Governor's Commission on Suicide Prevention. | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Planning is proceeding on the 2010 Annual Suicide Prevention Conference. The Coordinator of the State Child Fatality Review Team continues as the DHMH/CMCH Title V representative on the planning committee. The conference is scheduled for October 6, 2010.

**c. Plan for the Coming Year**
The Coordinator of the State Child Fatality Review Team has also been selected to serve as designee for the Deputy Secretary of Public Health Services on the Governor's Commission on Suicide Prevention.

The Mental Hygiene Administration, in collaboration with the Governor's Commission and CMCH, will continue to plan and implement the annual statewide adolescent suicide prevention conference. Title V funds will continue to be used to help in underwriting conference costs. There will also be periodic media campaigns, and school based youth suicide prevention programs.

Finally, the MCH Program will review vital statistics data, YRBS results and data from other sources to gain a better picture of the magnitude of youth suicide and related factors (e.g., depression) in Maryland as part of the next MCH needs assessment.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 87.5 | 89.5 | 89.6 | 89.7 | 89.8 |
| Annual Indicator | 88.7 | 87.8 | 89.3 | 89.4 | 89.4 |
| Numerator | 1070 | 1138 | 1138 | 1156 | 1156 |
| Denominator | 1206 | 1296 | 1275 | 1293 | 1293 |
| Data Source | | | | MD DHMH, Vital Statistics Admin 2008 | MD DHMH, Vital Statistics Admin 2008 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 92 | 92 | 92 | 92 | 92 |

**Notes - 2009**
Source: MD DHMH Vital Statistics Administration, 2008
Data for 2009 is currently unavailable

**Notes - 2008**

Source: MD DHMH Vital Statistics Administration, 2008

**Notes - 2007**
Data provided by Vital Statistics Administration.

**a. Last Year's Accomplishments**
The Center for Maternal and Child Health (CMCH) continued to work to improve hospital-specific birth outcomes and to lower neonatal mortality rates by promoting the standard that all very low birth weight (VLBW) infants should be born at Level III perinatal centers. Level I and Level II hospitals should make every effort to keep the number of VLBW births at those hospitals as close to zero as possible. Among 2008 births, 89.4% of very low birth weight infants born in Maryland were delivered at Level III facilities, 7.3% were born at Level II hospitals, and 3.3% were delivered at Level l hospitals.

In FY 2009, CMCH and MD Vital Statistics Administration (VSA) again provided hospital-specific data on VLBW births and deaths to all birthing hospitals in the State. Data are presented by encoded hospital of birth, and hospitals are grouped into 3 levels of perinatal care, as outlined in the Maryland Perinatal System Standards. The Standards were developed in 1995 as voluntary standards for Maryland hospitals providing obstetric and neonatal services. The Standards have been incorporated into the regulations for perinatal referral centers (Level III) by the Maryland Institute of Emergency Medical Services Systems (MIEMSS), and into the Maryland Health Care Commission's State Plan regulations for obstetric units and neonatal intensive care units. The goal of providing hospital-specific data is to improve compliance with the Standards, to reduce the number of VLBW births outside of Level III facilities, and to improve the quality of obstetric and neonatal care in Maryland hospitals.

The Department of Health and Mental Hygiene's (DHMH) Perinatal Clinical Advisory Committee (PCAC) completed a full review and update of the Maryland Perinatal System Standards to ensure consistency with AAP and ACOG standards. The updated Standards were released in October 2008 and again specify that VLBW infants should be born at Level III perinatal centers. The updated Standards are available on the CMCH website at http://fha.maryland.gov/mch/perinatal_standards.cfm ,

Title V funding continued to support the Maryland Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site high-risk consultation services provided by the State's two academic medical centers to obstetric provider. This service provides outreach education as well as clinical consultations that allow rural patients to remain in their communities rather than traveling to metropolitan areas of the State for specialty consultations.

With the Maryland Patient Safety Center, Title V continued to support a Perinatal Learning Network, a continuation of the Perinatal Collaborative begun in 2006. The Network includes 25 member hospitals, with the goal of improving patient safety in labor and delivery units. Focus areas include improving communication, team building, standardizing electronic fetal monitoring, reducing nosocomial infections, and reducing elective deliveries prior to 39 weeks gestation. CMCH is also participating in a Neonatal Collaborative, initiated in FY 2009 by the Maryland Patient Safety Center. Members include 27 hospitals in Maryland, the District of Columbia and Northern Virginia. The goal of this Collaborative is to improve patient safety in neonatal intensive care units. Focus areas include improving communication, team building, reducing central line-associated bloodstream infections, and standardizing initial resuscitation and stabilization of VLBW infants. With the National Perinatal Information Center, the Collaborative is collecting pre and post-intervention data.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service |
|---|---|

| | DHC | ES | PBS | IB |
|---|---|---|---|---|
| 1. Provide hospital specific data on VLBW births and deaths to Maryland hospitals. | | | | X |
| 2. Collect and anaylze perinatal data. | | | | X |
| 3. Review, update and disseminate the MD Perinatal System Standards. | | | | X |
| 4. Provide technical assistance to improve compliance with Standards. | | | | X |
| 5. Support and expand statewide program of telemedicine and on-site high-risk consultation services. | | | | X |
| 6. Work with the Maryland Patient Safety Center to improve quality of care in hospital settings. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

In FY 2010, CMCH with VSA again provided hospital-specific data on VLBW births and deaths to all birthing hospitals in the State.

CMCH also completed regulations (36:19 Md R. 1436), effective September 21, 2009, to codify the State's Fetal and Infant Mortality Review (FIMR) Program, and establish a statewide Morbidity, Mortality, and Quality Review (MMQR) Committee. The initial meeting of the MMQR Committee is scheduled for June 30, 2010. The Committee's purpose is to provide statewide oversight of morbidity and mortality associated with pregnancy, childbirth, infancy, and early childhood. Based on the findings from data review, the Committee is to develop and implement interventions to improve the system of care. Specifically, the regulations authorize the Committee to monitor Maryland hospitals with obstetric or neonatal services for their compliance with the Maryland Perinatal System Standards.

As part of the GDU project, CMCH has supported expansion of the MAPSS program of telemedicine and on-site high-risk obstetric consultation services provided by the State's 2 academic medical centers. CMCH continues to support and participate in the Maryland Patient Safety Center's Perinatal Collaborative. CMCH is also an active participant in the Neonatal Collaborative, initiated in FY 2009 by the Maryland Patient Safety Center.

**c. Plan for the Coming Year**

CMCH, with VSA, will continue to provide Maryland hospitals with hospital-specific data on VLBW births and deaths, and to monitor perinatal outcomes in the State. These activities will be enhanced by the statewide Morbidity, Mortality, and Quality Review (MMQR) Committee, established in regulation, which will convene in late FY2010. Specifically, the Committee is charged with monitoring hospital compliance with the Maryland Perinatal System Standards, including the standard that all VLBW infants should be born at Level III perinatal centers. To promote compliance with the Standards, CMCH will conduct site visits at all Maryland Level I and II hospitals beginning in FY 2011. CMCH will also begin planning with the Maryland Institute of Emergency Medical Services Systems (MIEMSS) for the next round of site visits of Level III centers.

CMCH will continue work with the Governor's Delivery Unit (GDU) to reduce infant mortality in Maryland. CMCH has begun work with the Governor's Delivery Unit on the Governor's Strategic Goal to reduce infant mortality in Maryland by 10% by 2012. This project has 3 specific focus areas: 1. healthier women before conception, 2. earlier entry into prenatal care, and 3. improved

perinatal and neonatal care.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 83.9 | 82.3 | 82.4 | 81 | 80 |
| Annual Indicator | 81.3 | 81.7 | 79.5 | 80.2 | 80.2 |
| Numerator | 59896 | 62261 | 62068 | 61969 | 61969 |
| Denominator | 73678 | 76248 | 78057 | 77268 | 77268 |
| Data Source | | | | MD Vital Statistics Annual Report 2008 | MD Vital Statistics, 2008 Annual Report |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 83 | 83 | 83 | 83 | 85 |

**Notes - 2009**
Source: MD Vital Statistics Administration, 2008 Annual Report; 2009 data currently unavailable

**Notes - 2008**
Source: MD Vital Statistics Administration, 2008 Annual Report

**a. Last Year's Accomplishments**
In FY 2009, the Babies Born Healthy Initiative continued to provide a comprehensive approach to improving perinatal health. Babies Born Healthy focuses on prevention services and quality improvement. Activities included increasing access to family planning and preconception services, perinatal and neonatal Collaboratives advancing patient safety for mothers and infants in Maryland hospitals, strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a partnership with the State's two academic medical institutions, and establishing standards for obstetric and neonatal care in Maryland's birthing hospitals. Updated Maryland Perinatal System Standards were published in October 2008.

On October 21, 2008, the Babies Born Healthy Leadership Forum was held in Baltimore, Maryland to enhance awareness about primary prevention strategies, quality improvement initiatives, and access to care issues related to improving pregnancy outcomes. The Forum provided a venue for Maryland leaders in health care, health policy, professional organizations, business, the faith community, advocacy groups, and the State legislature to develop strategies and solutions to improve birth outcomes in Maryland.

In FY 2009, CMCH also began work with the Governor's Delivery Unit (GDU) to develop a plan to

achieve the Governor's Strategic Goal of reducing infant mortality in Maryland by 10% by 2012. The plan will have 3 specific focus areas: 1. healthier women before conception, 2. earlier entry into prenatal care, and 3. improved perinatal and neonatal care. The second focus area directly addresses this performance measure.

In 2008, the percentage of Maryland women accessing first trimester prenatal care increased slightly to 80.2%, after more than a decade of decline. According to Maryland Vital Statistics Administration (VSA), first trimester prenatal care rates in 2008 varied by race and ethnicity, but improved in all racial and ethnic groups, with the greatest percentage increase among Hispanic women: 88.3% (?0.8%) among non-Hispanic white women, 73.9% (?0.4%) among Black women, 65.6% (?2.6%) among Hispanics women.

The Healthy People 2010 goal is 90% of women initiating prenatal care within the first trimester. In 2008, two Maryland counties (Carroll and Howard) met or surpassed the 2010 goal. In three jurisdictions, first trimester prenatal care percentages were 15% or more below the 2010 goal: Allegany County (70.8%), Baltimore City (73.7%) and Prince George's County (68.7%).

The Maryland PRAMS Data Book for 2004-2008 continued to show that the leading reasons why women do not begin prenatal care in the first trimester relate to lack of health care coverage and availability of obstetric services. The top five reasons, in order, were: 1. didn't have insurance or enough money, 2. couldn't get appointment, 3. didn't have Medicaid card, 4. doctor/health plan would not start care earlier, and 5. keeping pregnancy secret.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. assess and monitor trends in the use of prental care. | | X | | |
| 2. Refer women to prenatal care services through the MCH hotline. | | X | | |
| 3. Fund local health department-based prenatal care services for low income, uninsured pregnant women. | | X | | |
| 4. Support fetal and infant mortality review processes in every jurisdiction to promote perinatal system improvements. | X | | | |
| 5. Promote the importance of early prenatal care in home visiting and care coordination programs. | X | X | X | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

In FY 2010, Babies Born Healthy Initiative programs continued to focus on prevention services, quality improvement, and data systems development. A state-of the-art web-based electronic birth certificate was implemented in January 2010, and will allow timelier and more complete reporting of data on birth outcomes. Other ongoing activities included increasing access to family planning and preconception services, perinatal and neonatal Collaboratives advancing patient safety for mothers and infants in Maryland hospitals, establishing standards for obstetric and neonatal care in Maryland's birthing hospitals, and strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a partnership with the State's two academic medical institutions.

**c. Plan for the Coming Year**

CMCH, with VSA, will continue to monitor the percent of women in Maryland receiving first trimester prenatal care. The Babies Born Healthy Initiative will continue to focus on prevention services, quality improvement, and data systems development. These activities will be enhanced by the state level Morbidity, Mortality, and Quality Review (MMQR) Committee, established in regulation, which will convene in late FY2010. This Committee will look at cross-cutting issues that affect morbidity and mortality in pregnancy, childbirth, infancy and early childhood. Specifically, the Committee is charged with monitoring hospital compliance with the Maryland Perinatal System Standards. CMCH will conduct site visits at all Maryland Level I and II hospitals beginning in FY 2011, and will begin planning with the Maryland Institute of Emergency Medical Services Systems (MIEMSS) for the next round of site visits of Level III centers.

The new Governor's Delivery Unit (GDU) Plan- CMCH will also continue to work with the strategic goal reducing infant mortality by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. CMCH is the lead agency with collaboration from the Office of Minority Health & Health Disparities, Medicaid, Alcohol & Drug Abuse Administration, Mental Hygiene Administration, WIC, and local health departments in the 3 target jurisdictions, as well as the Department of Human Resources and the Governor's Office for Children. Programs and strategies focus on the three critical periods before, during, and following pregnancy, and include:

. Family planning service expansion to a broader Comprehensive Women's Health model, with the goal of healthier women at the time of conception and planned pregnancies.

. Implementation of a Medicaid Accelerated Certification of Eligibility (ACE) process, providing coverage for pregnant women beginning within 48 hours of an abbreviated application process and continuing up to 90 days while a full Medicaid application is completed, with a goal of earlier entry into prenatal care.

. "Quickstart" prenatal care services at the three local health departments, with expanded screening and referral services, and deployment of community outreach workers, with a goal of risk-appropriate early prenatal care.

. A standardized post-partum discharge referral process for birthing hospitals statewide, piloted in the three target jurisdiction, assuring coordination between hospitals, providers, local health departments and community services, with a goal of risk-appropriate follow-up services for mothers and infants. Promoting "Safe Sleep" will be a key component.

## D. State Performance Measures

**State Performance Measure 1:** *Percent of pregnancies that are intended*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 58.9 | 60 | 60 | 60 |
| Annual Indicator | 57.0 | 59.7 | 56.7 | 57.6 | 57.6 |
| Numerator | 42682 | 46226 | 44258 | 39285 | 39285 |
| Denominator | 74880 | 77430 | 78057 | 68248 | 68248 |
| Data Source | | | | MD PRAMS Report 2008 | MD PRAMS 2008 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 60.5 | 60.5 | 60.5 | 60.5 | |

**Notes - 2009**
Source: MD PRAMS Report, 2008; 2009 data currently unavailable

**Notes - 2008**
Source: MD PRAMS Report, 2008

**Notes - 2007**
Source: Estimate based on findings from the 2006 PRAMS report. Data for 2007 is unavailable.

**a. Last Year's Accomplishments**
In 2008, there was an increase in intended pregnancies to 57.6% up from 56.6% in 2007. The U.S. Healthy People 2010 goal is for no less than 70% of pregnancies to be intended.

The Title X Maryland Family Planning Program subsidizes family planning, preconception health, teen pregnancy prevention and colposcopy services provided to women and families in every jurisdiction in the State. The Title X Maryland Family Planning Program serves approximately 70,000 clients annually at 80 sites. Adolescents represent one third of persons served.

The Center began working with family planning programs in three jurisdictions: Baltimore City, Prince George's County, as part of a pilot to expand their scope of services to become Comprehensive Women's Health Centers under the Governor's Delivery Unit (GDU) initiative to reduce infant mortality. These programs will promote preconception health, screen for chronic disease conditions, mental health and substance abuse prevention, and provide counseling for women seen in the clinics as part of Comprehensive Women's Health services. A comprehensive Reproductive Health Life Plan form specific to the Maryland Family Planning Program will be developed, based on a review of existing literature and forms from other programs, train clinic staff, pilot test then evaluate use of the comprehensive Reproductive Health Life Plan document and process in the GDU jurisdictions. In the targeted GDU jurisdictions, the Center will work with Medicaid, WIC/Nutrition Services, Mental Health, and other referral sources to insure prompt referral to/from family planning services to maximize women's health before pregnancy.

Program will promote strategies to insure facilitated/earlier entry into prenatal care for women found to be pregnant, and referral for any conditions, which could negatively affect the health of the woman and her baby. Through collaboration with the Office of Minority Health and Health Disparities, the Program will support culturally competent outreach and education efforts in the community to target hard to reach families and address minority health needs. Changes will be implemented in Maryland Family Planning Program Data System (Ahlers System) to track Comprehensive Women's Health services in the targeted jurisdictions and referrals to/from other services. Share strategies for preconception health and comprehensive women's health promotion with other agencies and staff.

The Medicaid Program provides coverage for family planning services to enrollees. In addition, a federal waiver allows the Program to continue coverage for women who are no longer eligible for Medicaid following pregnancy. Eligible women may receive comprehensive family planning and reproductive health services including contraceptives. However, less than one in three eligible women are receiving services according to Medicaid claims files. Family planning program staff in several jurisdictions, including Baltimore City indicate that many women are still not aware of their eligibility for Medicaid waiver services. This continues to serve as a barrier to care.

The Center for Maternal and Child health continue to support the Babies Born Healthy and the Early Childhood Health Plans. Both initiatives promote strategies to improve access to family planning and preconception health services. Babies Born Healthy is a response to a worsening in the State's perinatal health indicators. This Initiative expanded access to preconception care, prenatal care and postpartum family services for uninsured and uninsurable pregnant women in local health departments and other safety net provider sites.

PRAMS data shows an increase in unintended pregnancy in teens from 69.6% in 2007 to 76.9% in 2008. Teen pregnancy prevention efforts are discussed under national performance measure #8.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Subsidize family planning and reproductive health clinical services to promote access to care in every jurisdiction in the state. | X | | | |
| 2. Distribute family planning brochures to all residents requesting a marriage license and insure availability of the brochure for distribution at community events and through otehr departments. | | | | X |
| 3. Analyze and disseminate PRAMS data on pregnancy intendedness in Maryland. | | | | X |
| 4. Refer Marylanders to family planning services through the MCH Hotline. | | | | X |
| 5. Continually update and disseminate family planning program administrative and clinical guidelines. | | | | X |
| 6. Identify and implement strategies to reduce teen and unintended pregnancies. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

CMCH was awarded a three-year (July 1, 2008 -- June 30, 2011) Title X Family Planning Supplemental Expansion grant to expand family planning clinical service delivery. Activities will continue under this grant to provide additional clinical services to populations in need in an underserved area of the state - particularly low-income individuals, teens and Hispanics - through strategies that include adding new service providers, linking with other community-based entities, and employing clinic efficiency strategies to enhance the ability to serve additional clients. Reproductive health expansion services are targeted to low income clients, with a focus on teen and Hispanic clients, in the Prince George's County/Greenbelt area, and will provide Title X services to an additional 2,500-3,000 clients in need of subsidized reproductive health care after the first project year. Service delivery partners include a federally qualified health center and the Maryland WIC Program.

**c. Plan for the Coming Year**

Ongoing activities will continue in FY 2010. The Family Planning Program will continue to operate, and focus on a critical assessment of family planning activities and needs both at state and local program levels, as part of a strategic planning process that will take the Program into the future. The MCH Program has prepared a budget initiative seeking additional funding for family planning services. According to the Guttmacher Institute, the Program is currently only able to serve less than half of the 200,000 Maryland women estimated to be in need of subsidized family planning services.

Data from Maryland PRAMS about teen pregnancy will be analyzed and published in a Focus brief in 2011.

Maryland plans to apply for federal funding for teen pregnancy prevention that is soon to be

available. Title V will partner with other DHMH programs and state agencies to implement new work plans.

**State Performance Measure 2:** *Percent of women reporting alcohol use in the last three months of pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 9.8 | 9.7 | 7 | 7 |
| Annual Indicator | 6.5 | 7.3 | 7.4 | 8.8 | 8.8 |
| Numerator | 4867 | 4842 | 4914 | 5921 | 5921 |
| Denominator | 74880 | 66619 | 66622 | 67513 | 67513 |
| Data Source | | | | MD PRAMS 2008 | MD PRAMS 2008 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 7 | 7 | 7 | 7 | |

**Notes - 2009**
Source: MD PRAMS 2008; 2009 data unavailable

**Notes - 2008**
Source: MD PRAMS 2008

**Notes - 2007**
MD PRAMS 2007

**a. Last Year's Accomplishments**
Prenatal alcohol exposure is the leading known cause of mental retardation. Alcohol exposure at any point during fetal development may cause permanent, lifelong disabilities. Fetal Alcohol Spectrum Disorder (FASD), the term given to disorders caused by prenatal alcohol exposure, was identified as an emerging priority during the 2005 Title V needs assessment. It is estimated that between 700 to 750 new cases of FASD occur in Maryland each year.

PRAMS data for 2008 indicate that too many Maryland women are continuing to drink during the last three months of pregnancy. A smaller percentage (< 1%) reported a binge drinking episode during the last three months of pregnancy. Alcohol use rates were highest for White women, women over the age of 35, and women with a more than a high school education. Local health department staff (particularly those in rural areas) surveyed for the Title V needs assessment indicated that they were seeing increasing evidence of alcohol addiction among pregnant women and women of childbearing age.

In 2006, a statewide FASD Coalition was formed. The Coalition includes representatives from State agencies (e.g., Education, Juvenile Services, Disabilities), DHMH agencies (e.g., Mental Health, Medicaid), universities and community groups. CMCH provides leadership and staffing for the Coalition and appointed a State FASD Coordinator in 2006. One major Coalition goal is to develop a long range plan for increasing awareness of FASD among all sectors -- health care, substance abuse treatment, social services, education, juvenile services, the faith community, business and industry as well as families and individuals. The Coalition has developed Work Groups to accomplish its tasks. Educational materials (e.g., posters, brochures) and a website have been developed for a public information campaign as mandated by Legislation passed in 2006.

In 2009, The FASD Coalition hosted many statewide outreach events and health Fairs and FASD Month Activities in September. The FASD Coalition meets quarterly with staff support from CMCH.

In 2010, the Maryland FASD Coalition sponsored a Social Workers Conference on FASD in cooperation with the University of Maryland, School of Social Work-Continuing Education Department. As a result is this successful conference, the School of Social Work has agreed to develop a curriculum on FASD for the School; to be taught by Kathy Mitchell, President of NOFAS and Co Chair of the Maryland FASD Coalition. At the SAMSHA FASD National Conference in May 2010 the MD FASD Coordinator conducted a presentation entitled: "Developing a State Coordinator Position." In May 2010, a new FASD State Plan was drafted.

CMCH and the FASD Coalition held the State's first FASD conference in September 2007. The conference featured both local and national experts and was geared towards professionals serving families affected by FASD. Over 150 professionals attended. The FASD Coordinator also collaborated with the Early Childhood Health Team to develop and implement a CME unit to increase provider awareness of the need to screen patients to prevent and/or address FASD. The target group for training is psychiatrists, psychologists, OB/GYNs, and pediatricians.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide administrative and staff support for a statewide coalition to address Fetal Alcohol Spectrum Disorders (FASD). | | | | X |
| 2. Implement a state mandated outreach and education program to raise awareness about FASD. Develop and disseminate outreach materials. | | | X | |
| 3. Maintain a FASD website. | | | | X |
| 4. Hold a statewide FASD conference to educate providers and other stakeholders about FASD. | | | | X |
| 5. Analyze data and publish issue briefs and reports on the problem of FASD in Maryland. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Activities this year have focused on continuing to promote awareness of FASD to professionals, women, teens and the general public. The FASD Coalition and its sub-committees are developing a web based FASD toolkit as a resource for women of childbearing age. The Coalition is sponsoring an educational meeting for professionals and service providers. The State Coordinator along with other committee members has been working with the Girls Scouts of Central Maryland to develop a Service Project to promote awareness of FASD among adolescent girls, during a health fair in October 2010.

**c. Plan for the Coming Year**

In the coming year, CMCH along with the FASD Coalition will focus on:
.Finalizing and widely disseminating a comprehensive five year action plan for prevention of FASD and improving the system of care families and individuals affected by FASD.
.Continuing a five year public information campaign based on recommendations in the FASD plan.
.Continuing to conduct continuing education seminars on FASD for physicians, health educators, school health personnel, foster care workers and juvenile justice staff.
.Collaborating with the Department of Juvenile Services providing a workshop to front line case managers.
.Organizing a curricula on FASD for University of Maryland, School of Social Work.
.Developing three webinars on FASD for educators and consumers.
.Organizing and hosting a 2nd statewide FASD conference in 2011.
.Analyzing available data on alcohol use during pregnancy.
.Identifying funding to sustain activities.

**State Performance Measure 3:** *Percent of Maryland kindergartners entering school ready to learn*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 61 | 67 | 68 | 69 |
| Annual Indicator | 60.0 | 67.0 | 67.0 | 73.3 | 77.8 |
| Numerator | 31889 | 37609 | 37609 | 42366 | 43525 |
| Denominator | 53148 | 56133 | 56133 | 57775 | 55965 |
| Data Source | | | | MSDE School Readiness Report 2008 | MSDE School Readiness Report, 2009 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 70 | 71 | 72 | 72 | |

**Notes - 2009**
Source: MSDE Children Entering School Ready to Learn, 2009-2010 Maryland Model for School Readiness

**Notes - 2007**
The Maryland Model for School Readiness (MMSR) defines early learning standards and indicators of what children should know and are able to do before they start formal education. The MMSR includes as its assessment component the Work Sampling System™ (WSS), a portfolio-based assessment system that helps teachers to document and evaluate children's skills, knowledge, behavior, and academic accomplishments across a variety of curricular areas. This is done by ongoing observation, recording, and evaluation of daily classroom experiences and activities that help teachers to gain a better understanding of what students know, are able to do, and areas requiring more work. The seven WSS™ learning domains are:
1. Social and Personal Development;
2. Language and Literacy;
3. Mathematical Thinking;
4. Scientific Thinking;
5. Social Studies;

6. The Arts;
7. Physical Development and Health.

**a. Last Year's Accomplishments**

At the beginning of each school year, Maryland kindergarten teachers assess the school readiness skills of incoming students. These data are used to track progress in school readiness and to help teachers revise their curriculum to meet the needs of all kindergarten children. In the 2009-2010 school year, 78% of Maryland kindergartners entered school fully ready to learn, a 26% jump from 49 percent in the 2001-2002 school year. However, significant gaps in school readiness remain between the children most in need (e.g., poor children, children with limited English proficiency and those lacking high-quality learning environments) as compared to their counterparts. During 2009, Maryland completed its fourth year of implementation of the ECCS State Plan- Growing Healthy Children. The Early Childhood Health Administrator, along with an Advisory Group of stakeholders, oversaw implementation of several strategies including:

. MD Social Emotional Foundations of Early Learning (MD-SEFEL): Implementation of a Train the Trainer model, building upon the existing MD-SEFEL model in Maryland, in partnership with the Mental Hygiene Administration, and Maryland State Department of Education. This was the third year for implementation of a 4 day statewide training to provide early childhood mental health training and measurement tools and further strengthen workforce development in Maryland.
. Child care health consultant training to train nurses to support the health environment of child care centers. In this third year, CMCH trained an additional 13 nurses from local health departments, school and community based and home health nurses to provide support and training on a myriad of early childhood health issues to licensed child care providers using the NTI training model developed at UNC.
. Head Start oral health needs assessment. The University of Maryland Dental School conducted an oral assessment of Head Start children in Maryland. The previous study, in 1999, formed the basis for providing oral health services in Baltimore City Head Start Programs. The results were to be used to further enhance both ECCS and the Oral Health State Plans. The dental health assessment could not be statistically validated because the sample size was too small. However, anecdotally, the same barriers appear to continue from the last needs assessment: transportation, access to providers, dental coverage, and knowledge of importance of dental health in the early years.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Implement the state's Early Childhood Health Plan. | | | | X |
| 2. Train regional child health consultants to work with childcare programs and support a MD-SEFEL training. | | | | X |
| 3. Support Head Start as needed on oral health related issues. | | | | X |
| 4. Represent DHMH on the interagency groups focused on improving school readiness. | | | | X |
| 5. Conduct a seminar on AA male school readiness and disparities. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Early Childhood Administrator continues to represent CMCH on numerous inter-agency groups addressing early childhood issues and works closely with the Maryland Department of Education (including Head Start, Infants and Toddlers, the Office of Child Care), the Governor's Office for Children, and the Mental Hygiene Administration. Partnership building and collaboration continued through CMCH representation on several interagency committees and work groups addressing early childhood health and school readiness issues. These include the Early Childhood Mental Health Steering Committee the Lead Commission and the State's Early Childhood Advisory Council. The Early Childhood Mental Health Steering Committee is charged to develop a plan for integrating mental health services into existing early childhood programs.

**c. Plan for the Coming Year**

Maryland will enter its fourth year of implementation of the ECCS State Plan: Growing Healthy Children in 2010. Maryland's State Early Childhood Plan integrates the development of early care and education services for all children from birth through five years of age that support children's early learning, health, and development of social competence. The plan addresses early care and education quality issues as well as the integration of health into all early care and education. Maryland continues to use the ECCS action plan and integrate the objectives to further enhance the quality of early care and education service delivery and promote the healthy physical, social and emotional development of all infants and young children.

In 2011 the ECCS project plans to:

. Fund and support MD-AAP sponsored regional trainings of family medicine and pediatric providers to promote developmental screening of all children. This objective is supported by ECCS through attendance on the ABCD stakeholders committee. ECCS will continue to support the project this coming year by attending meetings as requested. Family medicine physicians were added to the training cadre when the needs assessment determined this group was inadvertently being omitted.

.Develop a plan to incorporate 96110 screening code for reimbursement for all providers and referral for all children receiving a developmental screening. Through the ABCD stakeholders committee in partnership with the MD-AAP, ECCS will continue to be present at the table to help move this agenda forward so that all physicians will receive reimbursement for early developmental screening. This objective was modified to specifically note a reimbursement code.

. Conduct a health fair for the Girl Scouts of Central Maryland.

ECCS has planned and coordinated a health fair that is scheduled to be held on October 16, 2010 for middle school and early high school aged girls. The topics covered include: oral health, young women's health, and behavioral/mental health. Information will be provided by various health vendors including the YMCA. The purpose of the fair is to ensure preventative health and increase education about the health of young children. This objective was added to the plan when it was determined that there was an overlap in young women's health and the health of children that are often cared for by babysitters.

.Develop a database to determine the numbers of children in childcare who are receiving mental health services and the impact on outcomes for children, families and childcare settings. ECCS would like to know if fewer children are being referred to services for behavioral challenges or expelled due to (1) the use of mental health consultants and (2) the ECCS supported trainings to increase the number of early childhood mental health consultants in the in the childcare setting.

**State Performance Measure 4:** *Rate of emergency department visits for asthma per 10,000 children, ages 0-4*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 170 | 200 | 220 | 220 |
| Annual Indicator | 203.1 | 221.9 | 186.5 | 186.5 | 143.0 |
| Numerator | 7749 | 8171 | 7026 | 7026 | 5315 |
| Denominator | 381487 | 368199 | 376745 | 376745 | 371787 |
| Data Source | | | | State Asthma Surveillance | HSCRC, 2008 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 218 | 218 | 218 | 218 | |

**Notes - 2009**
Data Source: HSCRC, 2008

**Notes - 2007**
Source: HSCRC Hospital Discharge data and ambulatory data. NCHS Vintage 2007 Population File

**a. Last Year's Accomplishments**
Statewide, about 12.9% of Maryland adults and 13.1% of children have a history of asthma. About 8.3% of adults and 8.9% of children currently have asthma. Emergency department (ED) visits, hospitalizations and mortality suggest a failure to manage asthma properly. Children under the age of five have the highest ED visit of any age group in Maryland. While the Healthy People 2010 goal is for 80 visits per 10,000 population, Maryland's youngest children had 184 visits per 10,000 in 2008.

The Maryland Asthma Control Program or MACP addresses both pediatric and adult asthma and is administratively housed in CMCH. The Maryland Legislature mandated establishment of the MACP in 2002 and charged the Program to develop a statewide asthma surveillance system and an asthma control program. Maryland has received a CDC asthma grant since 2001 that supports staff salaries (i.e., an asthma epidemiologist, administrator and evaluator) and funds sub-grantees. Title V partially supports the costs of administrative staff, program printing and the purchase of educational materials.

MACP continued to implement select interventions to reduce asthma morbidity and mortality in 2009. The seventh edition of the Asthma Surveillance Report was completed. Chapters address asthma among Medicaid enrollees, emergency room and hospitalization usage and racial/ethnic disparities in asthma morbidity and mortality. The Program maintains a Website that includes a Maryland Asthma Resource Guide, the most recent asthma surveillance report and other educational materials is available at www.marylandasthmacontrol.org.

An Asthma Action Plan has been developed for use by families and providers to ensure that appropriate actions are taken to control asthma. Health care providers from across the State participated in educational programs focused on adherence to the NHLBI Guidelines and the importance of the Asthma Action Plan. The Asthma Action Plan is available through the MACP to individuals, families, schools and communities.

Asthma continues to disproportionately affect African American children in Maryland, particularly those living in Baltimore City. Title V funding to the Baltimore City Health Department supported

the Childhood Asthma Program. This Program provides outreach, education and home-based case management to families of young children (ages < 6) affected by asthma. Parents/caregivers are educated about the importance of eliminating environmental triggers and proper asthma medical management.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Administer the Maryland Asthma Control Program. | | | | X |
| 2. Continue asthma surveillence activities including annual publication of surveillence reports and briefs. | | | | X |
| 3. Revise the State's Asthma Control Plan. Refine and implement a statewide plan to address disparities in asthma outcomes. | | | | X |
| 4. Fund local health department based asthma interventions including support to local and regional asthma coalitions. | | | | X |
| 5. Co-chair and provide staff support for the MD Asthma Coalition. | | | | X |
| 6. Provide staff support for the Children's Enviornmental Health Advisory Council. | | | | X |
| 7. Collaborate with state and local healthy homes initiatives. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Maryland Asthma Control Plan: An Action Agenda to Reduce the Burden of Asthma in Maryland 2010-2015 was published in April 2009. Throughout, 2010, the MACP Program Coordinator has given presentations on and distributed the Agenda during meetings with the Children's Environmental Health and Protection Advisory Council, the Coalition to End Childhood Lead Poisoning, the Greater Baltimore Asthma Alliance and the Montgomery County Latino Health Initiative.

In August 2009, MACP was awarded continued asthma grant funding under a highly competitive grant application from the CDC. The grant funding period will continue until 2014. MACP piloted the Asthma Friendly Schools Initiative (AFSI) in 2009. The AFSI was established in 25 schools in Maryland located in Baltimore County, Baltimore City and Garrett County. At least ten more schools are excepted to be designated as Asthma Friendly in August 2010.

**c. Plan for the Coming Year**

-Maintaining and expanding the asthma surveillance system. MACP anticipates continued participation in the BRFSS Asthma Call Back Survey. This Survey will provide data on the frequency and severity of asthma episodes, treatment and management practices, environmental controls and exposure, cost, etc. MACP has published five annual comprehensive surveillance reports (2002- 2007), In addition, MACP anticipates an in-depth analysis of Medicaid and MCHP claim/encounter data, particularly assessing prescription drug utilization among children and adults with asthma.

-Educating parents/caregivers, patients and the public about asthma prevalence, treatment and best practices management. The University of Maryland Breath mobile will continue to receive support to conduct education and case management for asthmatic children in Baltimore City.

Activities and outreach will take place to educate providers and health officials concerning the updated NAEPP Guidelines.

-Educating providers, nurses and pharmacists in underserved locations (Eastern Shore, Western Maryland, Baltimore City) regarding proper asthma diagnosis and adherence to the NAEPP Guidelines.

-Continuing to support and maintain the Maryland Asthma Coalition and Executive Committee. The Executive Committee serves as an advisory group to MACP staff and guides the Coalition in creation and implementation of asthma specific outreach programs.

-Promoting healthy environments to lessen the impact of asthma. MACP will continue its partnership with a national coalition to educate child care providers concerning the effects of the indoor environment on asthmatic children. This Healthy Homes approach includes in-home education and home assessment for asthma triggers within Prince George's County and in Dorchester County.

-Developing an "action plan" to address disparities in outcomes.

**State Performance Measure 5:** *Percent of Maryland 12th graders who graduate from high school*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 84.9 | 86 | 86.1 | 86.2 |
| Annual Indicator | 84.8 | 85.4 | 85.4 | 96.5 | 85.2 |
| Numerator | | 51800 | 51800 | 59626 | 58304 |
| Denominator | | 60656 | 60656 | 61767 | 68403 |
| Data Source | | | | Summary of Attendance Maryland Public Schools 2007 | MSDE, 2009 Maryland Report Card |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 86.3 | 86.4 | 86.4 | 90 | |

**Notes - 2009**
Source: MSDE, 2009 Maryland Report Card

**Notes - 2008**
Data from Summary of Attendance Maryland Public Schools 2007-2008

**Notes - 2007**
Source:  Estimate based on Maryland State Department of Education, Maryland Report Card for the 2006/2007 School year.

**a. Last Year's Accomplishments**
Adolescence, however it's defined (ages 10 - 19 or 12-19 or 13-21), is a time of tremendous change and growth. This transitional developmental period between childhood and adulthood offers many physical, mental and emotional challenges. Risk taking is the norm during this period.

While many adolescents make the transition to adulthood with few problems; others do not fare as well. During the 2005 Title V needs assessment, focus groups with parents and service providers consistently identified the need to promote healthy, positive youth development by offering adolescents "a sense of the future." The health care delivery system was viewed as "unfriendly" to adolescents and ill equipped to address growing mental health, psycho-social and emotional problems of teens. Adolescent health promotion was chosen as an MCH priority to highlight the unique needs and issues that affect this often overlooked segment of the MCH population within the public health system.

Evidence is mounting that school success largely depends on whether students are safe, healthy, and resilient. Positive health status has been linked to many aspects of academic achievement including improved test scores, retention, and decreased absenteeism. In Maryland 96.8% of high school seniors graduated in the 2008-2009 school year (Maryland Summary of Attendance Report 2008-2009).

CMCH employs a Medical Director for Child and Adolescent Health as well as a State Adolescent Health Coordinator to oversee planning, policy development and program implementation for school and adolescent health. In addition, support for adolescent health is provided by a community health educator who oversees teen pregnancy prevention efforts and consults with Family planning program staff who work with teens.

DHMH and the State Department of Education are jointly responsible for developing standards and guidelines for school health programs and offering assistance to county boards of education and local health departments in implementing these standards and guidelines. CMCH is responsible for promoting the health of school aged children and ensuring that schools comply with mandated school health standards. The Medical Director for School and Adolescent Health continued to provide medical consultation on school and adolescent issues in 2007.

MCH provided several training opportunities in 2009 to promote healthy and positive youth development The School Health Interdisciplinary Program (SHIP) meeting held in August 2009, provided intensive professional development opportunities to school health and youth serving agency professionals. Training sessions focused on skill building to reduce risky behaviors among adolescents and to promote positive youth development.

Since 2008, CMCH has collaborated with the Johns Hopkins Center for Adolescent Health in the development and launch of a publication for professionals who work with youth, parents and community members called "The Teen Years Explained: A Guide to Healthy Adolescent Development." This printing of this document came after several years of collaboration on this valuable resource guide. The guide contains concepts on various issues that can be lifted out as a resource for specific groups. The guide will serve as a resource which provides guidance to a broad audience on issues related to optimal adolescent health and well-being.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Co-sponsor the annual School Health Interdisciplinary Program (SHIIP), a four day institute designed to educate school personnel about a broad spectrum of health and social issues that impact school retention and performance. | | | | X |
| 2. Implement strategies to prevent teen pregancy and improve life chances for students. | | | | X |
| 3. Monitor and publish data on adolescent health including assets and risk factors that impact school retention and performance. | | | | X |

| | | | | |
|---|---|---|---|---|
| 4. Conduct child fatality reveiw processess to identify prevention strategies to protect teens. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Adolescent Health Coordinator serves as the staff point person and coordinator of the Adolescent Health Colloquium.

The Medical Director for School and Adolescent Health continues to represent the MCH Program on the statewide planning initiative, Ready by 21 sponsored by the Governor's Office for Children. The goal is prepare Maryland children and adolescents to be productive, healthy citizens and prepared for the workforce by the age of 21. Improving high school graduation rates is one of the objectives. The document, Ready By 21, was completed in April of 2010.

**c. Plan for the Coming Year**

Ongoing activities will continue in FY 2011.

CMCH is also currently taking steps to convene an adolescent health data collaborative to assist in promoting healthy adolescent development in Maryland. This involves pulling together representatives of State agencies involved with adolescent data issues to identify adolescent "hot spots" across the State to support policy and program development. These data would be used to (1) develop and refine adolescent health performance measures for the MCH performance monitoring system an(2) to identify communities most in need of positive youth development The School Health Interagency Program is scheduled for August 1 -5, 2010, at Sheraton North Hotel in Towson, Maryland. The title for 2010 is "Adjusting our Sails; Charting a New Direction for our Children's Future" and includes topics covering the eight components of comprehensive school health. Speaker's topics include working with at risk youth, immigrant youth and families, mental health issues in school health, gangs, youth suicide prevention, alcohol and substance abuse, conflict resolution in schools, trauma history and it's effects on school performance and motivational interviewing, asthma management in schools and others. The Center for Maternal & Child Health is disseminating guides to various stakeholders.

## State Performance Measure 6: *Percentage of local jurisdictions addressing the issue of respite for families of CSHCN*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 75 | 62.5 | 62.5 |
| Annual Indicator | 70.8 | 66.7 | 62.5 | 62.5 | 62.5 |
| Numerator | 17 | 16 | 15 | 15 | 15 |
| Denominator | 24 | 24 | 24 | 24 | 24 |
| Data Source | | | | OGCSHCN Grantee Reports | OGCSHCN Grantee Reports |
| Is the Data Provisional or | | | | Final | Final |

| Final? | | | | | |
|---|---|---|---|---|---|
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 62.5 | 66 | 66 | 70 | |

**Notes - 2009**
Source: Data from OGCSHCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

**Notes - 2008**
Source: Data from OGCSHCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

**Notes - 2007**
Source: Data from OGCSHCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

Annual Performance Objectives have been revised based on the most recent data.

**a. Last Year's Accomplishments**
In FY09, the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) awarded respite funds to 15 of Maryland's 24 local jurisdictions. With continued level funding of the Block Grant and persistent State budget problems, local jurisdictions have been forced to tap into respite monies to cover the cost of living adjustments for their staff providing other services to CYSHCN such as care coordination. In fact, the overall funding for respite has steadily decreased from FY05 to FY08, with a corresponding decrease in numbers of children and families served (over 30%.)

Despite this, local jurisdictions, in collaboration with families and community agencies, continued to have success in developing creative and cost effective respite initiatives. Their efforts provided funding to a total of 634 CYSHCN, and increase from FY08 in which only 581 CYSHCN received respite funds. These respite opportunities included a combination of "respite hours" and funds for camps. Funding was not limited to any particular special health care need or disability; diagnoses varied from diabetes, asthma, and heart disease to epilepsy, Down Syndrome, and cerebral palsy. In FY09, Kennedy Krieger Institute (KKI) became the administrator for respite funds for CYSHCN in Baltimore City. The program "My Own Time" provided over $20,000 of respite funding for a total of 64 CYSHCN in Baltimore City (part of the total of 634 children statewide.)

The OGCSHCN also provided funding in FY09 to disease-specific advocacy organizations to support operation of summer camps for CYSHCN. The Maryland Alliance of PKU Families received support for PKU Camp, a family camp which served 102 individuals in FY09. Monies were also awarded to support the operation of Camp New Friends, a camp for children with neurofibromatosis. In FY09, there were 80 CYSHCN with neurofibromatosis who participated in the camp.

The data source is OGCSHCN Grantee Reports- the system will not allow me to enter that in the appropriate box.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide grants to local jurisdictions to support a variety of respite care activities. | | X | | |
| 2. Provide grants to disease specific advocacy organizations to | | X | | |

| | | | | |
|---|---|---|---|---|
| support operation of summer camps for CSHCN. | | | | |
| 3. Refer families to other potential sources of funding for respite care. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Kennedy Krieger continues to be the administrator for respite funds for CYSHCN in Baltimore City. The program, "My Own Time" has been a success as the specialty care hospital is a great referral source for children and youth who would most benefit from respite care. In FY10, the OGCSHCN Community Systems Development Coordinator worked with staff at the Wicomico County Health Department to better negotiate the agreement the county has with the local hospital, which provides subspecialty care to CYSHCN in the county with funds from OGCSHCN. Recent contractual changes had nearly eliminated respite care for FY09. OGCSHCN staff continues to work with LHD staff to access other types of programs and funding for more respite care for CYSHCN throughout the state. OGCSHCN continues to refer families of CYSHCN to other sources of respite funding for which they may be eligible including funding through the Developmental Disabilities Administration, the Department of Human Resources, and disease specific foundations. OGCSHCN again awarded funds for the PKU and neurofibromatosis camps, and reinitiated a Sickle Cell Day Camp after several years.

**c. Plan for the Coming Year**

This will no longer be a state performance measure.

## State Performance Measure 7: *Percent of mothers breastfeeding at six months*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 42 | 44 | 46 | 48 |
| Annual Indicator | 40.8 | 40.8 | 40.8 | 43.0 | 43.0 |
| Numerator | 29085 | 29085 | 29085 | 31860 | 31860 |
| Denominator | 71286 | 71286 | 71286 | 74094 | 74094 |
| Data Source | | | | 2006 NIS applied to Vital Stats 2006 infant pop | 2006 NIS applied to Vital Stats 2006 infant pop |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 50 | 50 | 50 | 50 | |

**Notes - 2009**

Source: 2009 data is currently unavailable; Percentage is from 2006 National Immunization Survey, CDC. This was applied to the infant population in 2006, as reported by Vital Statistics Administration

**Notes - 2008**
Source: 2008 data is currently unavailable; Percentage is from 2006 National Immunization Survey, CDC. This was applied to the infant population in 2006, as reported by Vital Statistics Administration

**Notes - 2007**
This is no longer a state performance measure because it is a national performance measure.

**a. Last Year's Accomplishments**
This measure has been retired as a state measure since it became a national performance measure in 2006.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. This measure has been retired as a state measure since it became a national performance measure in 2006. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
This measure has been retired as a state measure since it became a national performance measure in 2006.

**c. Plan for the Coming Year**
This measure has been retired as a state measure since it became a national performance measure in 2006.

## State Performance Measure 8: *Percent of local jurisdictions with written plans to address racial and ethnic disparities in maternal and child health*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 2 | 10 | 15 | 15 |
| Annual Indicator | 8.3 | 8.3 | 8.3 | 12.5 | 12.5 |
| Numerator | 2 | 2 | 2 | 3 | 3 |
| Denominator | 24 | 24 | 24 | 24 | 24 |
| Data Source | | | | Survey of LHD MCH | Survey of LHD MCH |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Programs | Programs |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 20 | 20 | 20 | 20 | |

**Notes - 2007**
Source: Survey of local health department MCH programs.

**a. Last Year's Accomplishments**
Maryland data show that there is (1) increasing racial/ethnic diversity within Maryland's population, (2) the existence of persistent and widespread racial and ethnic disparities in maternal and child health, and (3) the urgent need to systematically address these disparities if the health of women, children and families in Maryland is to improve. With few exceptions (e.g., suicide and substance use), African American mothers, babies, children and adolescents fare far worse than other racial/ethnic groups on most measures of mortality, morbidity, health and social status, and access to health care. Twenty of the State's 24 jurisdictions have racial and ethnic minority populations greater than 10%. In 2009, local health departments in at least two jurisdictions had developed written plans or program initiatives for addressing racial and ethnic disparities.

The Maryland General Assembly created the Maryland Office of Minority Health and Health Disparities (OMHHD) in 2004. OMHHD holds annual staff conferences that are attended by title V staff. The 2009 conference focused on improving cultural competency and highlighted the need to diversify the health care workforce and increase the cultural competency of all heath care providers.

Perinatal disparities continued to be addressed under the Babies Born Healthy Initiative initiated with new State funding in 2009. This Program was designed to address recent increases in the State's infant mortality rate as well as known disparities in perinatal outcomes.

Dr. Marsha Smith, the Medical Director for Perinatal Health, is participating in a workgroup to develop a cultural and linguistic competence self-assessment tool for use by Fetal and Infant Mortality Review (FIMR) teams. The members of the workgroup are from Washington, D.C.; Virginia; and Maryland fetal and infant mortality review programs. The development of this self assessment tool is a new effort supported by collaboration between the National Center for Cultural Competence and the National Fetal and Infant Mortality Review Program. Dr. Smith also has also prepared and given a presentation on "Racial and Ethnic Disparities in Pregnancy Outcomes" before several groups this year as part of the Babies Born Healthy Initiative.

At the request of the OMHHD, CMCH recently completed a plan to address MCH disparities in four areas: adverse birth outcomes, asthma, teen pregnancy and lead poisoning. Strategies include data collection and analysis, participation in collaborative efforts with other agencies and provider groups, and the dissemination of policy briefs and reports. The Plan will be shared with local health departments to encourage similar plan development within their communities.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Survey local health departments to determine activities. | | | | X |
| 2. Participate on committees convened by the Office of Minority Health and Health Disparities to address racial and ethnic disparities in family health programs. | | | | X |

| | | | | |
|---|---|---|---|---|
| 3. Work with the Family Health Administration to develop a strategy to adddress racial and ethnic disparities in family health programs. | | | | X |
| 4. Develop and disseminate issue and policy briefs on MCH disparities. | | | | X |
| 5. Develop and implement a plan to address MCH disparities. | | | | X |
| 6. Educate local MCH program directors and staff about MCH disparities. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Title V is currently completing the 2010 title V needs assessment. The population based assessment of the 2010 needs assessment includes and examination of major disparities for evaluation by age, race/ethnicity and jurisdiction. A data brief on major health disparities is being prepared.

**c. Plan for the Coming Year**
CMCH will continue to address MCH disparities in 2011. A health disparities webpage will be developed for the CMCH Website and a data brief on MCH disparities will be completed and disseminated to local programs. These activities were planned for last year as well, but limited staffing precluded their completion. CMCH plans to hire a new senior MCH epidemiologist with funding through the SSDI grant to complete work on disparities.

Technical assistance will be sought from the DHMH Office of Health Disparities to develop a model for working with local health department MCH staff to address disparities.

The Asthma control Program will work with OMHHD and advocacy groups to compelte an action plan or reducing disparities in asthma outcomes. Major disparate groups include African Americans and Baltimore City residents.

**State Performance Measure 9:** *Percent of jurisdictions that partner with medical homes to develop and to disseminate resource materials.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 41.6 | 50 | 58.3 | 45 |
| Annual Indicator | 33.3 | 41.7 | 41.7 | 41.7 | 37.5 |
| Numerator | 8 | 10 | 10 | 10 | 9 |
| Denominator | 24 | 24 | 24 | 24 | 24 |
| Data Source | | | | OGCSHCN Grantee Reports and survey of LHDs | OGCSHCN Grantee Reports |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance | 50 | 54 | 58 | 62 | |

| | | | | | |
|---|---|---|---|---|---|
| Objective | | | | | |

**Notes - 2009**
Source: OGCSHCN survey of local jurisdictions. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care providers to share with families.

**Notes - 2008**
Source: OGCSHCN survey of local jurisdictions. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care providers to share with families.

**Notes - 2007**
OGCSHCN survey of local jurisdictions. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care providers to share with families.

**a. Last Year's Accomplishments**
Throughout the 2005 needs assessment, we heard that families of CYSHCN often lack information about available community resources and how to effectively access them. This was true for both health-related resources and family support services. Follow-up data from Maryland families indicated that while doctor's offices are the place where parents most often receive information about their CYSHCN, these offices are not seen as the most effective source of information, and parents would like more information related to both medical and non-medical issues than they are currently receiving. Additional data from Maryland pediatricians confirmed that their offices lack information about important state and local resources, and that pediatricians don't feel like they have the time or personnel to put this together for their practice.

Based on data from the local health departments, at least 9 jurisdictions reported sharing their resource materials directly with medical home providers in order to make the information available to families.

Last year, the Baltimore City Health Department (BCHD), with grant support from OGCSHCN, continued "The Medical Homes Project." This project uses lessons learned from the pharmaceutical industry, which has proven itself extremely effective in "getting in the door" at medical sites and sharing its messages and products. The strategy of this project is to successfully engage pediatric primary care practice staff over provided lunches, with the staff of BCHD programs (Baltimore City Infants and Toddlers, Baltimore City Healthy Start, Healthy Families, Maternal and Infant Nursing, Baltimore HealthCare Access, the Childhood Asthma Program, and Child Find) to share information/resources, to make personal contacts, and to identify ways the systems of care can coordinate efforts on behalf of the children that they serve, particularly at-risk children and infants/young children with SHCN. Like the pharmaceutical companies, this effort included distribution of branded "leave-behind" items. Such as mouse pads, pens, and post-it notepads, all imprinted with contact information for the above programs in order to foster better communication and more referrals. . In FY09 the project conducted "public health detailing" with 14 primary care sites across Baltimore City, and continued to retrain 3 primary pediatric care sites on developmental screening and referrals. Materials were distributed at all initial and follow-up sessions. CDs that contained program referral forms, brochures, and samples of correspondence for each program were developed and distributed. These CDs enable practices to have comprehensive information about each program in one place.

The Parents' Place of Maryland (PPMD), in partnership with OGCSHCN, was awarded a State Implementation Grant from MCHB. Block grant funded staff from OGCSHCN provided critical leadership staff support to develop the Community of Care (CoC) Maryland Consortium for CYSHCN. An inaugural summit was held in November 2008. Participants identified and prioritized strategies to improve access statewide to medical home, one of which is to create an ongoing

inventory of community resources.
OGCSHCN completed the development of brief (1-3 page) resource lists for each jurisdiction that are posted to the web, linked to a map of state counties. These lists continue to be readily accessible by pediatric health care providers in order to share with families. These lists are not exhaustive but meant to be a starting point for families in finding health-related and family support services for their child. The availability of these lists is publicized to providers and families through multiple mechanisms including the Maryland Chapter of the AAP, PPMD, and local health department staff.

The OGCSHCN "Children's Resource Line" was staffed by its Community Systems Development Coordinator. In the last quarter of FY09 the OGCSHCN fielded an average of 13 calls per month.

The data source is OGCSHCN Grantee Reports and survey of LHDs but the system will not allow nme to enter that in the appropriate box or in the notes.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Support medical homes project to link Baltimore City pediatric primary care practices with the Baltimore City Health Department. | | X | | X |
| 2. Develop and share resource information with medical home providers throughout the state through multiple mechanisms. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Plans for this year had involved hiring another staff person at OGCSHCN to work on the State Implementation grant, however this did not occur, and progress on the medical home goal for the CoC and for the state on this performance measure has been impeded. The Maryland chapter of the American Academy of Pediatrics (MD AAP) and the CoC had plans to partner in a series of 4 regional forums to bring together physicians, allied health providers, local health departments, community service providers, families, and others to discuss medical home and the integration of medical home approaches into the pediatric practices in their regions. This did not occur during FY10, however plans have now been finalized to hold 3 of the 4 forums in the first quarter of FY11. In FY10, the Baltimore Medical Homes Project expanded; One of the participating groups, Johns Hopkins Community Physicians (JHCP), would like to implement the program statewide in all 18 of their practices. A new group, Baltimore Medical Services, is joining the project and would like to implement it at all 6 of their practices that serve children. One of the currently participating practices, East Baltimore Medical Center (EBMC) has expressed an interest in branching out from the already implemented improved developmental screening and referral processes and incorporating more medical home building processes.

**c. Plan for the Coming Year**
This performance measure is not continued for FY11.

**State Performance Measure 10:** *Number of policy or issue briefs developed by the Title V program*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 3 | 1 | 1 | 1 |
| Annual Indicator | | 3 | 3 | 4 | 7 |
| Numerator | | 3 | 3 | 4 | 7 |
| Denominator | 1 | 1 | 1 | 1 | 1 |
| Data Source | | | | CMCHdatabase | CMCHdatabase |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 1 | 1 | 1 | 1 | |

**Notes - 2008**
Source: Center for Maternal and Child Health Database

**a. Last Year's Accomplishments**
In FY2009, the Center for Maternal and Child Health (CMCH) produced many policy and issue briefs. They also made numerous data translation presentations to inform local, state, and national organizations of the results of CMCH efforts. The documents are available via the CMCH website at: www.fha.maryland.gov/mch. The Maryland Asthma Control Program produced a comprehensive report on the burden of asthma in Maryland for 2007, as well as five data briefs on topics related to asthma hospitalizations, and asthma in early childhood and the elderly. They also released a series of 24 jurisdictional profiles on asthma. The Babies Born Healthy initiative published revised Maryland Perinatal Systems Standards and discussed these standards at multiple forums and conferences. The Children's Environmental Health and Protection Advisory Council produced its 2008 annual report documenting their legislative reviews and public outreach activities. The State Child Fatality Review Team developed and facilitated the distribution of three newsletters and the annual State CFR Team Report for 2007. The Early Childhood Comprehensive System Initiative published a State Plan of Implementation, 2009-2012. The 2007 Annual Report on Childhood Blood Lead Surveillance in Maryland was developed by the Maryland Childhood Lead Screening Program. CMCH developed several brochures on the benefits of breastfeeding and initiated a new awards program to promote breastfeeding friendly workplaces. The Maryland Fetal Alcohol Spectrum Disorders Coalition developed FASD brochures aimed at consumers and health care providers. Information on the causes and contributing factors associated with maternal mortality were published in the 2008 State Maternal Mortality Review Report. The Maryland Pregnancy Risk Assessment Monitoring System program issued two focus briefs on smoking during pregnancy and postpartum, and on breastfeeding. They also published the 2007 report on survey results. CMCH staff made a poster presentation on risk factors associated with smoking during pregnancy based on PRAMS data at the 2008 American Public Health Association Conference. A poster presentation, also utilizing PRAMS data on smoking and postpartum depression was given at the 2008 CDC PRAMS Conference. There were also two journal articles published based on Maryland PRAMS data. The first, published in 'The Journal of Pediatric Urology' focused on neonatal circumcision. The second addressed unintended pregnancy and was published in 'Contraception'. CMCH efforts toward improving women's health resulted in the development of a brochure on depression in women and the publication of a data book focused on the health of women in Maryland. An article on depression among pregnant and postpartum Latinas was published in the 'Maternal and Child Health' journal.

The Office of Genetics and Children with Special Health Care Needs (OGCSHCN) was similarly busy with data translation efforts in FY2009. Their documents can be found at the website: www.fha.maryland.gov/genetics. This office contributed to a summit for the Maryland

Community of Care Consortium for CSHCN, and developed six briefs for the summit. These briefs focused on family-professional partnerships, medical homes, adequate insurance, early screening, community-based services, and transition to adulthood. OGCSHCN also held regional meetings for the dissemination of information to local health departments. Office staff made numerous presentations to local hospitals, schools, and professional associations on the Maryland newborn hearing screening program. An article on factors associated with neonatal thyroid hormone status was published in 'Thyroid'. An article which found that birth delivery mode modifies associations between PCB and PBDE and neonatal thyroid hormone levels was published in 'Environmental Health Perspectives'. A third article on newborn screening for X-linked Adrenoleukodystrophy was published in 'Molecular Genetics and Metabolism'. OGCSHCN also published a legislative report on whether newborn screening should be mandatory for all infants in Maryland.

A more complete list of data translation efforts for FY2009 is included in the Title V Needs Assessment.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Develop and disseminate MCH issue or policy breifs on surveillance data, qualitative analyses, analysis of secondary data sources and/or literature reveiw of evidence based interventions. | | | | X |
| 2. Develop and disseminate a Title V Performance Measure Databook. | | | | X |
| 3. Develop and disseminate a Title X Performance Measure Databook. | | | | X |
| 4. Expand analysis of the PRAMS and Asthma surveillance systems. | | | | X |
| 5. Develop and disseminate reports of state and local FIMR findings. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

In FY2010 the Center for Maternal and Child Health (CMCH) developed and disseminated many data translation and policy reports and presentations. The documents are available via the CMCH website at: www.fha.maryland.gov/mch. A new Governor's initiative for reducing infant mortality led to the development of a state plan, which was presented at various forums to Health Officers, Medicaid MCO medical directors, and the State Drug and Alcohol Abuse Council. The Maryland Asthma Control Program developed six briefs focused on these asthma areas: early childhood, racial and ethnic disparities, childhood obesity and asthma, repeat hospitalizations, hospitalizations in the National Capital Region, and BRFSS Survey results. CMCH staff published an article in 'Obstetrics and Gynecology' on intimate partner homicide among pregnant and postpartum women. The Maryland Pregnancy Risk Assessment Monitoring System Program developed and distributed four focus briefs based on PRAMS data on these pregnancy topics: oral health, alcohol use, Medicaid coverage, and comments from Maryland mothers. The PRAMS program also produced the 2008 PRAMS Report and a roll-up report based on births between 2004 and 2008. The entire Title V Program staff contributed towards a Title V Stakeholders meeting, which was held to disseminate information and gather input about many aspects of Title

V supported program.

**c. Plan for the Coming Year**

In FY2011, the Center for Maternal and Child Health (CMCH) plans to continue its active data translation activities. The Maryland Asthma Control Program expects to issue an ‘Asthma in Maryland 2009' data book. They also anticipate developing data briefs on medication usage among asthmatics, asthma care coverage, work-related asthma, and asthma in school and child care. The Children's Environmental Health and Protection Advisory Council will produce its 2010 annual report documenting their legislative review and public outreach activities. The State Child Fatality Review Team plans to release their annual report, as well as additional newsletters on child injury prevention. CMCH will also produce the 2009 Child Death Report. The Fetal and Infant Mortality Review Program will develop and disseminate a report of state and local FIMR findings. The Maryland Childhood Lead Screening Program will report on Childhood Blood Lead Surveillance in Maryland for 2009. Staff from CHCH expects to publish a journal article on the Maryland Healthy Kids Obesity Study. The Maryland Fetal Alcohol Spectrum Disorders Coalition will give a presentation at the SAMSHA ‘Building FASD State Systems' Conference, and will also work with the Caregivers Coordinating Support Council to produce the annual Governor's Report. The Maryland State Maternal Mortality Review will produce the 2010 state report based on their annual data review. The Maryland Pregnancy Risk Assessment Monitoring System Program plans to release six new focus briefs on the following topics: prepregnancy BMI, PRAMS data reported by county, postpartum depression, births among adolescents, births among women ages 35 and over, and intimate partner violence. The team will also produce the annual report based on 2009 births. The team will submit an abstract for presentation at the 2010 CDC PRAMS Conference. They also expect to submit an article on oral health preventive care to the ‘Maternal and Child Health' journal. CMCH staff have two publications coming out in FY2011. The first is an article in ‘Preventing Chronic Disease' about improving pregnancy outcomes through integration of women's health services. The second is a chapter in a book titled ‘Alcohol Use during Pregnancy', which describes epidemiology and policy regarding alcohol use during pregnancy.

The Office of Genetics and Children with Special Health Care Needs (OGCSHCN) is planning to make data based presentations at two upcoming Maryland Community of Care Consortium for CSHCN meetings. This office has recently experienced significant staffing losses, and so further plans for data translation activities will be defined at a later date.

A more complete list of data translation efforts planned for FY2011 is included in the Title V Needs Assessment.

## E. Health Status Indicators

**Introduction**

Health status indicator data is collected from several sources including Vital Statistics, the Injury and Sexually Transmitted Infections surveillance systems, and State program databases. Form 21 provides important data on the socio-demographic and socio-economic characteristics of children in Maryland. Social factors are important determinants of health. These data are used to monitor trends in social factors that may have either a negative or positive effect on the health of Maryland children. The data are distributed to MCH staff at the State and local levels to assist with program planning and policy development.

**Health Status Indicators 01A:** *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Indicator | 9.2 | 9.4 | 9.1 | 9.3 | 9.3 |
| Numerator | 6869 | 7294 | 7133 | 7186 | 7186 |
| Denominator | 74880 | 77430 | 78057 | 77268 | 77268 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: 2009 data is currently unavailable; Percent of births <2,500 grams provided by Vital Statistics Report, 2008. Total number of live births from Vital Statistics Report, 2008.

**Notes - 2008**
Source: Percent of births <2,500 grams provided by Vital Statistics Report, 2008. Total number of live births from Vital Statistics Report, 2008.

**Narrative:**
According to the Maryland Vital Statistics Administration and the National Center for Health Statistics, low birthweight (LBW) births have increased over the past decade, both nationally and in Maryland. Comparing 1999 and 2008 data, LBW births are up 7.9% nationally, but up only 2.2% in MD. Over this period, LBW births in MD increased by 7.5% among white infants, but fell by 3.6% among Black infants. Among Hispanic infants, LBW births have increased by 9.2% from 2000 when data were first collected. From 2007 to 2008, LBW births in MD increased by 2%, from 9.1% to 9.3%. There was no change in the national percentage at 8.2%, according to preliminary data.

The MD percent LBW remains above the national average (9.1% in MD vs 8.2% in the U.S. for 2008 births). Although MD's overall percent LBW is higher than the national average, race and ethnic specific percentages in MD are generally at or below the US rates. In 2008, 7.2% of white infants, 13.2% of Black infants, and 7.1% of Hispanic infants were LBW in MD, compared with 7.2% white, 13.7% Black, and 7.0% Hispanic nationally. The higher overall percent of LBW in MD is the result of demographics in the State.

CMCH is involved in many initiatives to reduce LBW births. In FY 2010, Babies Born Healthy Initiative programs continued to focus on prevention services, quality improvement, and data systems development. A state-of the-art web-based electronic birth certificate was implemented in January 2010, and will allow timelier and more complete reporting of data on birth outcomes. Other ongoing activities included increasing access to family planning and preconception services, perinatal and neonatal Collaboratives advancing patient safety for mothers and infants in Maryland hospitals, establishing standards for obstetric and neonatal care in Maryland's birthing hospitals, and strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a partnership (the MD Advanced Perinatal Support Services [MAPSS]) with the State's two academic medical institutions. In FY 2009, CMCH completed regulations for House Bill 535, passed by the MD Legislature in 2008. The regulations codify the State's FIMR Program, and establish a Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood. This Committee will convene in late FY 2010.

The new Governor's Delivery Unit (GDU) Plan addresses the Governor's strategic goal to reduce infant mortality by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by

expanding prevention services, improving infrastructure, and building new models and systems of care. 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. CMCH is the lead agency with collaboration from various state agencies.

**Health Status Indicators 01B:** *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 7.2 | 7.3 | 7.2 | 7.2 | 7.2 |
| Numerator | 5188 | 5441 | 5373 | 5318 | 5318 |
| Denominator | 72020 | 74295 | 75083 | 74109 | 74109 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: 2009 data is currently unavailable; Vital Statistics Administration, 2008

**Notes - 2008**
Source: Vital Statistics Administration, 2008

**Narrative:**
According to the Maryland Vital Statistics Administration and the National Center for Health Statistics, low birthweight (LBW) births have increased over the past decade, both nationally and in Maryland. Comparing 1999 and 2008 data, LBW births are up 7.9% nationally, but up only 2.2% in MD. Over this period, LBW births in MD increased by 7.5% among white infants, but fell by 3.6% among Black infants. Among Hispanic infants, LBW births have increased by 9.2% from 2000 when data were first collected. From 2007 to 2008, LBW births in MD increased by 2%, from 9.1% to 9.3%. There was no change in the national percentage at 8.2%, according to preliminary data.

The MD percent LBW remains above the national average (9.1% in MD vs 8.2% in the U.S. for 2008 births). Although MD's overall percent LBW is higher than the national average, race and ethnic specific percentages in MD are generally at or below the US rates. In 2008, 7.2% of white infants, 13.2% of Black infants, and 7.1% of Hispanic infants were LBW in MD, compared with 7.2% white, 13.7% Black, and 7.0% Hispanic nationally. The higher overall percent of LBW in MD is the result of demographics in the State.

The Center for Maternal and Child Health (CMCH) is involved in many initiatives to reduce LBW births. In FY 2010, Babies Born Healthy Initiative programs continued to focus on prevention services, quality improvement, and data systems development. A state-of the-art web-based electronic birth certificate was implemented in January 2010, and will allow timelier and more complete reporting of data on birth outcomes. Other ongoing activities included increasing access to family planning and preconception services, perinatal and neonatal Collaboratives advancing patient safety for mothers and infants in Maryland hospitals, establishing standards for obstetric and neonatal care in Maryland's birthing hospitals, and strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a

partnership (the MD Advanced Perinatal Support Services [MAPSS]) with the State's two academic medical institutions. In FY 2009, CMCH completed regulations for House Bill 535, passed by the MD Legislature in 2008. The regulations codify the State's FIMR Program, and establish a Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood. This Committee will convene in late FY 2010.

**Health Status Indicators 02A:** *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 1.9 | 1.9 | 1.9 | 1.9 | 1.9 |
| Numerator | 1415 | 1473 | 1474 | 1462 | 1462 |
| Denominator | 74880 | 77430 | 78057 | 77268 | 77268 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: Vital Statistics Administration, 2008 Report
2009 data is currently unavailable

**Notes - 2008**
Source: Vital Statistics Administration, 2008 Report

**Narrative:**
The new Governor's Delivery Unit (GDU) Plan addresses the Governor's strategic goal to reduce infant mortality by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. CMCH is the lead agency with collaboration from the Office of Minority Health & Health Disparities, Medicaid, Alcohol & Drug Abuse Administration, Mental Hygiene Administration, WIC, and local health departments in the 3 target jurisdictions, as well as the Department of Human Resources and the Governor's Office for Children. Programs and strategies focus on the three critical periods before, during, and following pregnancy, and include:
. Family planning service expansion to a broader Comprehensive Women's Health model, with the goal of healthier women at the time of conception and planned pregnancies.
. Implementation of a Medicaid Accelerated Certification of Eligibility (ACE) process, providing coverage for pregnant women beginning within 48 hours of an abbreviated application process and continuing up to 90 days while a full Medicaid application is completed, with a goal of earlier entry into prenatal care.
. "Quickstart" prenatal care services at the three local health departments, with expanded screening and referral services, and deployment of community outreach workers, with a goal of risk-appropriate early prenatal care.
. A standardized post-partum discharge referral process for birthing hospitals statewide, piloted in the three target jurisdiction, assuring coordination between hospitals, providers, local health departments and community services, with a goal of risk-appropriate follow-up services for

mothers and infants. Promoting "Safe Sleep" will be a key component. CMCH will also conduct site visits at all MD Level I and II hospitals to promote compliance with the Perinatal Standards. In 2010, CMCH will begin planning with the MD Institute of Emergency Medical Services Systems (MIEMSS) for the next 5-year site visit reviews of Level III centers.

**Health Status Indicators 02B:** *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 |
| Numerator | 1064 | 1095 | 1090 | 1089 | 1089 |
| Denominator | 72020 | 74283 | 75083 | 74109 | 74109 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: Vital Statistics Administration, 2008
2009 data is currently unavailable

**Notes - 2008**
Source: Vital Statistics Administration, 2008

**Narrative:**
The new Governor's Delivery Unit (GDU) Plan addresses the Governor's strategic goal to reduce infant mortality by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. CMCH is the lead agency with collaboration from the Office of Minority Health & Health Disparities, Medicaid, Alcohol & Drug Abuse Administration, Mental Hygiene Administration, WIC, and local health departments in the 3 target jurisdictions, as well as the Department of Human Resources and the Governor's Office for Children. Programs and strategies focus on the three critical periods before, during, and following pregnancy, and include:
. Family planning service expansion to a broader Comprehensive Women's Health model, with the goal of healthier women at the time of conception and planned pregnancies.
. Implementation of a Medicaid Accelerated Certification of Eligibility (ACE) process, providing coverage for pregnant women beginning within 48 hours of an abbreviated application process and continuing up to 90 days while a full Medicaid application is completed, with a goal of earlier entry into prenatal care.
. "Quickstart" prenatal care services at the three local health departments, with expanded screening and referral services, and deployment of community outreach workers, with a goal of risk-appropriate early prenatal care.
. A standardized post-partum discharge referral process for birthing hospitals statewide, piloted in the three target jurisdiction, assuring coordination between hospitals, providers, local health departments and community services, with a goal of risk-appropriate follow-up services for mothers and infants. Promoting "Safe Sleep" will be a key component. CMCH will also conduct

site visits at all MD Level I and II hospitals to promote compliance with the Perinatal Standards. In 2010, CMCH will begin planning with the MD Institute of Emergency Medical Services Systems (MIEMSS) for the next 5-year site visit reviews of Level III centers.

**Health Status Indicators 03A:** *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 7.0 | 5.2 | 6.5 | 5.5 | 5.5 |
| Numerator | 81 | 58 | 72 | 60 | 60 |
| Denominator | 1153348 | 1112945 | 1113284 | 1099652 | 1099652 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: MD Vital Statistics Administration, 2008
Data for 2009 is currently unavailable

**Notes - 2008**
Source: MD Vital Statistics Admin, 2008

**Notes - 2007**
Source: 2006 Md. Vital Statistics Report. Data for 2007 is currently unavailable.

**Narrative:**
Strategies to maintain and/or improve the death rate due to intentional injuries among children aged 14 and younger include the assessment of deaths by the Child Fatality Review Teams (CFRT) that exist in every jurisdiction in Maryland.
The teams review and analyze each death and report any community/systems issues that impacted or contributed to the death. Recommendations are made to the community to prevent any recurrences. These recommendations may include the need for policy changes, community education and resource development.

The Center for Maternal and Child Health provides administrative support to the CFRT. The CFRT receives reports on child deaths from the Office of the State Medical Examiner and these reports form the foundation of the case reviews.

In 2009 the State CFR focused on amending the law to allow local CFR teams to participate in a system of electronic data entry offered free to states by the National Center for Child Death Review. Over time, participation in this system will improve state data and allow for better understanding of child deaths and improve planning to address them. Additionally, there has been on-going focus on injury prevention in relation to MVC's. Also, Safe Sleep remains an area of great concern and teams are encouraged to use and promote the trainings offered by the Center for Infant and Child Loss which focuses its efforts on safe sleep. Likewise, CMCH staff

participate in meetings and trainings offered by the Partnership for a Safer Maryland and Safe Kids, two organizations dedicated to injury prevention.

**Health Status Indicators 03B:** *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 2.4 | 2.5 | 2.8 | 2.3 | 2.3 |
| Numerator | 28 | 28 | 31 | 25 | 25 |
| Denominator | 1153348 | 1112945 | 1113284 | 1099652 | 1099652 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: MD Vital Statistics Administration, 2008 Report
Data for 2009 is currently unavailable.

**Notes - 2008**
Source: MD Vital Statistics Administration, 2008 Report

**Notes - 2007**
Source: 2006 Maryland Vital Statistics Report. Data for 2007 is currently unavailable.

**Narrative:**
In 2008 the death rate in children age 14 and under from Motor Vehicle Crashes was 2.3 per 100,000. Strategies to maintain and/or improve the death rate due to intentional injuries among children age 14 and under due to MVC's include the assessment of deaths by the Child Fatality Review Teams (CFRT) operating in each jurisdiction in Maryland. These teams review and analyze each death and report any community/systems issues that impacted the death. Recommendations are made to the community to prevent recurrences. These recommendations may include the need for policy changes, changes to laws, community education and resource development.

The Center for Maternal and Child Health provides administrative support to the state CFRT. The CFR teams in Maryland receive monthly reports from the Office of the State Medical Examiner on the children who have died, and these reports form the foundation of the case review.

A good collaboration exists with the Children's Safety Network and the Partnership for a Safer Maryland which provide networking meetings and training programs to prevent MVC's (and other injuries) among children 14 years and younger, as well as older individuals. Additionally, a program promoting use and training regarding child safety seats is a very active in Maryland. It is implemented under the Center for Health Promotion and Education within the Family Health Administration at the MD Department of Health and Mental Hygiene.

Finally, during the 2009 legislative session, a law was passed that enables data from child fatality review meetings to be shared electronically with the National Center for Child Death Review. This will improve data collection and eventually allow for better understanding and assessment of child fatalities in Maryland.

**Health Status Indicators 03C:** *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 19.1 | 21.6 | 22.0 | 17.1 | 17.1 |
| Numerator | 149 | 169 | 173 | 134 | 134 |
| Denominator | 781675 | 780609 | 786990 | 784401 | 784401 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: MD Vital Statistics Adminstration, 2008 Report
2009 data is currently unavailable.

**Notes - 2008**
Source: MD Vital Statistics Administration, 2008 Report

**Notes - 2007**
Source: 2006 Maryland Vital Statistics Report. Data for 2007 is currently unavailable.

**Narrative:**
Influences to maintain and/or improve the death rate due to intentional injuries among children aged 15 to 24 year olds due to MVC's include the assessment of deaths by Child Fatality Review Teams (CFRT) that operate in every jurisdiction in Maryland and the subsequent systems changes that are implemented. The teams review and analyze each death and report any community/systems issues that impacted the death, to prevent recurrences. Recommendations are made to the community that may include the need for policy changes or changes to laws, community education or resource development.

The Center for Maternal and Child Health provides administrative support to the state CFRT. The CFRT in Maryland receives reports on child deaths from the Office of the State Medical Examiner, and these are used as the foundation of case reviews. CMCH addresses MVC deaths up to the age of 18, although the Center for Health Promotion and Injury Prevention addresses the older age limits. Teen MVC's have been an ongoing focus in Maryland, with safe teen driving education and auto safety provided in many venues and for a variety of audiences. Issues of attention, distracted driving, interacting with friends and speed affect these age groups at a much higher rate that older adults.

The Partnership for Safer Maryland and Safe Kids Program are two of the lother groups addressing the issue of teen driving and deaths. CMCH staff participate in both these programs.

Finally, during the 2009 legislative session, a law was passed that enables data from child fatality review meetings to be shared electronically with the National Center for Child Death Review. This will improve data collection and eventually allow for better understanding and assessment of child fatalities in Maryland.

**Health Status Indicators 04A:** *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 204.6 | 191.5 | 201.5 | 201.2 | 201.2 |
| Numerator | 2360 | 2131 | 2232 | 2212 | 2212 |
| Denominator | 1153348 | 1112945 | 1107687 | 1099652 | 1099652 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: HSCRC, hospital discharge data, 2008
Data for 2009 is currently unavailable

**Notes - 2008**
Source: HSCRC hospital discharge data, 2008

**Notes - 2007**
Data Source: HSCRC Hospital Discharge Dataset for 2007, MDP population estimate for 2007. Excludes Ecodes E870-E879, E930-E949 (adverse event injuries due to medical, surgical, drugs).

**Narrative:**
n 2008, the rate of non-fatal injuries among children aged 14 and younger was 201.1 per 100,000.

The Maryland State Child Fatality Review Team (SCFRT) oversees local review cases of unusual and unexpected child fatality (under age 18) to learn how such deaths might be prevented in the future. Several years ago the State Team developed a definition of "near fatality", to assist local child fatality teams, particularly low-death counties, in reviewing non-fatal incidents. While only a few teams have yet ventured into this area, it is anticipated that in time there will be more reviews of non-fatal instances. This will take development of a system of notification from the emergency rooms of hospitals, to allow teams to learn about near fatalities occurring in their jurisdiction. The current system in place notifies of fatalities only. Notice comes through the Office of the Chief Medical Examiner (OCME) and, of course, the OCME only knows about fatalities, not near fatalities.

In 2009, the SCFRT also worked to change state law so local teams could enter fatality data from case reviews into a national data entry system sponsored and funded by the National Center for

Child Death Review. This system will eventually also help with data collection and assessment of near fatalities.

Some members of the state and child fatality review teams also attend the meetings of "Safe Kids Maryland", which looks at all areas of injury risk to develop reduction strategies.

The Partnership for a Safer Maryland (PSM) is an organization started by the DHMH Center for Health Promotion and Education. Public and private organizations from across the state participate in PSM meetings and trainings, to identify risk areas and strategies for injury prevention. The PSM provides a monthly newsletter, technical assistance for data and networking with other injury prevention professionals.

**Health Status Indicators 04B:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 23.6 | 23.1 | 21.8 | 15.6 | 15.6 |
| Numerator | 272 | 257 | 241 | 171 | 171 |
| Denominator | 1153348 | 1112945 | 1107687 | 1099652 | 1099652 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: HSCRC hospital discharge data, 2008; Data for 2009 is currently unavailable

**Notes - 2008**
Source: HSCRC hospital discharge data, 2008
Data for 2009 is currently unavailable

**Notes - 2007**
Source: HSCRC Hospital Discharge Dataset for 2007.

**Narrative:**
In 2008, the rate of non-fatal injuries due to motor vehicle accidents for children aged 14 and younger was 15.6 per 100,000.

The Maryland State Child Fatality Review Team (SCFRT) oversees local review of cases of unusual and unexpected child fatality under age 18, (including MVA's) to learn how such deaths might be prevented in the future. Several years ago the SCFRT developed a definition of "near fatality" to assist local child fatality teams, particularly low-death counties, in reviewing non-fatal incidents. While only a few teams have yet ventured into this area, it is anticipated that in time there will be more reviews of non-fatal MVA's and other injuries. This will take development of a system of notification from the emergency rooms of hospitals, to allow teams to learn about near fatalities occurring in their jurisdiction. The current system in place notifies of fatalities only.

Notice comes through the Office of the Chief Medical Examiner (OCME) and, of course, the OCME only knows about fatalities, not near fatalities.

The State Child Fatality Review Team also worked to change state law so local teams may enter fatality data from case reviews into a national data entry system sponsored and funded by the National Center for Child Fatality Review. This system will eventually also help with data collection and assessment of near fatalities, including MVA's in children 14 and under.

Some members of state and child fatality review teams attend the meetings of "Safe Kids Maryland", which looks at all areas of injury risk to develop reduction strategies. Safe Kids even has a special "Occupant Protection Task Force" to address the needs of children in vehicles.

The Partnership for a Safer Maryland (PSM) is a group started several years ago under the auspices of the Center for Health Promotion and Education. Public and private organizations from all areas of the state participate in PSM meetings and trainings, to identify risk areas and strategies for injury prevention. The PSM has had a sub-committee on MVA's and also provides a monthly electronic newsletter, technical assistance for data, and networking with other injury prevention professionals.

**Health Status Indicators 04C:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 226.8 | 230.7 | 213.0 | 186.5 | 186.5 |
| Numerator | 1773 | 1801 | 1676 | 1463 | 1463 |
| Denominator | 781675 | 780609 | 786789 | 784401 | 784401 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: HSCRC, hospital discharge data, 2008
Data for 2009 is currently unavailable

**Notes - 2008**
Source: HSCRC, hospital discharge data, 2008

**Notes - 2007**
Source: HSCRC Discharge Dataset for 2007, MDP population data for 2007.

**Narrative:**
In 2008, the rate of non-fatal injuries due to motor vehicle accidents for youth aged 15-24 years was 186.5 per 100,000.

The Maryland State Child Fatality Review Team (SCFRT) oversees local review of cases of unusual and unexpected child fatality under age 18, to learn how such deaths might be prevented in the future. MVA's claim many lives in the 15 to 24 age group and cause even more injuries.

Several years ago the SCFRT developed a definition of "near fatality" to assist local child fatality teams, particularly low-death counties, in reviewing non-fatal incidents. While only a few teams have yet ventured into reviewing near-fatalities, it is anticipated that in time there will be more reviews of non-fatal MVA's and other injuries. This will take development of a system of notification from the emergency rooms of hospitals, to allow teams to learn about near fatalities occurring in their jurisdiction. The current system in place notifies of fatalities only. Notice comes through the Office of the Chief Medical Examiner (OCME) and, of course, the OCME only knows about fatalities, not near fatalities.

The State Child Fatality Review Team worked to change state law so local teams may enter data from case reviews into a national data entry system sponsored and funded by the National Center for Child Fatality Review. This system will eventually also help with data collection and assessment of near fatalities as well as fatalities, including MVA's, but only in children under 18.

Some members of state and child fatality review teams attend the meetings of "Safe Kids Maryland", which looks at all areas of injury risk to develop reduction strategies. Safe Kids does take a special interest in MVA's and even has a special "Occupant Protection Task Force" to address the needs of children and teens in vehicles.

The Partnership for a Safer Maryland (PSM) is a group started several years ago under the auspices of the Center for Health Promotion and Education. Its efforts are not limited to children, so it covers the age range in this health status indicator. Public and private organizations from all areas of the state participate in PSM meetings and trainings, to identify risk areas and strategies for injury prevention. The PSM has had a sub-committee on MVA's and also provides a monthly electronic newsletter, technical assistance for data, and networking with other injury prevention professionals. The Coordinator of the State Child Fatality Review Team and members of local teams attend the PSM meetings, finding them very valuable.

**Health Status Indicators 05A:** *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 32.0 | 35.1 | 39.1 | 40.2 | 40.2 |
| Numerator | 6323 | 7163 | 7827 | 8033 | 8033 |
| Denominator | 197367 | 204122 | 200269 | 199714 | 199714 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2008

Data for 2009 is currently unavailable.

**Notes - 2008**
Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2008

**Notes - 2007**
Source: Maryland Division of Sexually Transmitted Diseases, MD DHMH, 2007

**Narrative:**
Modest increases in Chlamydia rates for teens reflect both trends of concern in prevention messages and positive activities in screening. Repeat infections among teens also are a public health issue, coupled with difficulties in accessing care for this age group. Cuts in public health spending affect expanding screening programs, or even maintaining services in the face of increasing health costs. On the positive side, detection rates increase when screening is increased, and when more sensitive tests are used, and when simpler testing is done via urine screening. These enhance the ability to treat cases and prevent serious sequelae.

Screening and treatment services for sexually transmitted infections are provided by the state STD Program and the Maryland Family Planning Program.

Influences on maintaining/improving HSIs include fiscal issues that affect testing supply costs and screening/prevention programs, availability of more sensitive (but more costly) detection tests, current evidence-based guidelines on routine and targeted screening, availability of urine screening, and abstinence-only messages vs. comprehensive sex education.

The Family Planning Program, State STD Program and State Laboratories Administration meet frequently internally and with regional IPP partners to discuss ways to improve screening, increase detection rates, promote prevention messages, and insure prompt treatment to reduce complications. Program guidelines stress the importance of screening the under 25 population, assessing those clients at highest risk, and providing prevention messages, including abstinence and correct use of condoms for those who are sexually active. The program provides condoms to local family planning/std programs as a means of promoting safer sex messages. In addition, program testing for Chlamydia is transitioning quickly to the more sensitive and accurate Nucleic Acid Amplification Test from the EIA test to further improve detection rates. Clinic sites are moving toward urine-based testing, which allows screening of young women who come for pregnancy tests or emergency contraception and do not receive a pelvic exam. Urine testing has a high level of acceptance and results in the ability to screen populations not previously screened but who are clearly sexually active.

Program activities include a close monitoring of treatment activities to insure positive cases get prompt treatment and partner evaluation. A pilot project in Baltimore City is testing Expedited Partner Therapy as another means to reduce Chlamydia rates by facilitating ease of treating partners of known cases. In addition, program clinic sites participate in providing treatment to positive testing clients who have requested and received test kits online.

**Health Status Indicators 05B:** *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 7.8 | 9.8 | 10.0 | 10.8 | 10.8 |
| Numerator | 7768 | 9719 | 9889 | 10604 | 10604 |
| Denominator | 996115 | 987698 | 989922 | 981479 | 981479 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2009**
Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2008

2009 data is currently unavailable

**Notes - 2008**
Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2008

**Notes - 2007**
Source: Maryland Division of Sexually Transmitted Diseases, MD DHMH 2007.

**Narrative:**
Modest increases in Chlamydia rates for women ages 20-44 have been occurring. Cuts in public health spending affect expanding screening programs, or even maintaining services in the face of increasing health costs. Many of the STD and Family Planning Clinics have combined services or offer services on the same day. Costs associated with testing require focusing screening on populations most at risk, and targeting testing according to specific risk criteria. At the Annual STD Program Update it was noted that the detection rates increased. The program intends to follow this closely to ensure that the most vulnerable 20-25 age group is being targeted and tested appropriately to assist in determining if the rise is due to an increase in the prevalence of Chlamydia.

**Health Status Indicators 06A:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

| **CATEGORY** TOTAL POPULATION BY RACE | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Infants 0 to 1 | 75362 | 42552 | 25091 | 380 | 4231 | 87 | 3021 | 0 |
| Children 1 through 4 | 296425 | 167242 | 98218 | 1293 | 16475 | 548 | 12649 | 0 |
| Children 5 through 9 | 361155 | 214471 | 113845 | 1451 | 17303 | 389 | 13696 | 0 |
| Children 10 through 14 | 366710 | 217603 | 120101 | 1284 | 16462 | 249 | 11011 | 0 |
| Children 15 through 19 | 407227 | 242410 | 137350 | 1466 | 16917 | 217 | 8867 | 0 |
| Children 20 through 24 | 377174 | 227530 | 123304 | 1524 | 17328 | 288 | 7200 | 0 |
| Children 0 through 24 | 1884053 | 1111808 | 617909 | 7398 | 88716 | 1778 | 56444 | 0 |

**Notes - 2011**

**Narrative:**
CMCH supports and participates in many programs to address the needs of children, and to address disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in 2008. High-risk obstetric services are provided by the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. The Office for Genetics and Children with Special Health Care Needs also supports programs for children with metabolic diseases, hemoglobinopathies and birth defects.

Other programs include the MD Asthma Control Program; MD Asthma Coalition; Teen Pregnancy Prevention; Lead Poisoning Prevention Commission; Fetal Alcohol Spectrum Disorders Coalition; Fetal and Infant Mortality Review; Child Fatality Review; Maternal Mortality Review; and a legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood that convened in early FY 2010 and the results incorporated into the Title V needs assessment.

**Health Status Indicators 06B:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

| **CATEGORY** TOTAL POPULATION BY HISPANIC ETHNICITY | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Infants 0 to 1 | 65544 | 9818 | 0 |
| Children 1 through 4 | 256209 | 40216 | 0 |
| Children 5 through 9 | 326721 | 34434 | 0 |
| Children 10 through 14 | 339223 | 27487 | 0 |
| Children 15 through 19 | 381557 | 25670 | 0 |
| Children 20 through 24 | 350075 | 27099 | 0 |
| Children 0 through 24 | 1719329 | 164724 | 0 |

**Notes - 2011**

**Narrative:**
CMCH supports and participates in many programs to address the needs of children, and to address disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in 2008. High-risk obstetric services are provided by the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. The Office for Genetics and Children with Special Health Care Needs also supports programs for children with metabolic diseases, hemoglobinopathies and birth defects.

Other programs include the MD Asthma Control Program; MD Asthma Coalition; Teen Pregnancy Prevention; Lead Poisoning Prevention Commission; Fetal Alcohol Spectrum Disorders Coalition; Fetal and Infant Mortality Review; Child Fatality Review; Maternal Mortality Review; and a legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood that convened in early FY 2010 and the results incorporated into the Title V needs assessment.

**Health Status Indicators 07A:** *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

| **CATEGORY** Total live births | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Women < 15 | 100 | 39 | 60 | 0 | 0 | 0 | 0 | 1 |
| Women 15 through 17 | 2055 | 898 | 1114 | 2 | 18 | 1 | 0 | 22 |
| Women 18 through 19 | 4475 | 2011 | 2375 | 8 | 41 | 2 | 0 | 38 |
| Women 20 through 34 | 56615 | 33953 | 18609 | 118 | 3649 | 9 | 0 | 277 |
| Women 35 or older | 14023 | 8720 | 3944 | 32 | 1267 | 7 | 0 | 53 |
| Women of all ages | 77268 | 45621 | 26102 | 160 | 4975 | 19 | 0 | 391 |

**Notes - 2011**

**Narrative:**
Maryland had 77,261 births in 2008, with 2,155 born to mothers <18 years old. The racial / ethnic breakdown was 59% white, 34% Black.

CMCH has many initiatives to improve birth outcomes and reduce disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in Oct. 2008. High-risk obstetric services are enhanced by the MD Advanced Perinatal Support Services, a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. CMCH supports FIMR, Child Fatality and Maternal Mortality Review programs throughout the State. A legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood will convene in early FY 2010. CMCH has also begun work with the Governor's Delivery Unit on the Strategic Goal to reduce infant mortality in MD by 10% by 2012. Focus areas are healthier women before conception, earlier entry into prenatal care, and improved perinatal neonatal care.

**Health Status Indicators 07B:** *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

| **CATEGORY** Total live births | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Women < 15 | 76 | 23 | 1 |
| Women 15 through 17 | 1658 | 396 | 1 |
| Women 18 through 19 | 3843 | 631 | 1 |
| Women 20 through | 48415 | 8166 | 34 |

| | | | |
|---|---|---|---|
| 34 | | | |
| Women 35 or older | 12691 | 1317 | 15 |
| Women of all ages | 66683 | 10533 | 52 |

**Notes - 2011**

**Narrative:**
For 2008, the birth rate among Hispanic women was substantially higher than among non-Hispanic women for all age groups. The birth rate among Hispanic adolescents has risen significantly since 2000, while the teen birth rate among non-Hispanic teens has declined. While infant mortality among older Hispanic mothers is lower than their White non-Hispanic counterparts, infant mortality among Hispanic teens is higher than among White non-Hispanic teens 15-17 years old.

**Health Status Indicators 08A:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

| **CATEGORY** Total deaths | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Infants 0 to 1 | 617 | 230 | 346 | 3 | 17 | 0 | 0 | 21 |
| Children 1 through 4 | 88 | 49 | 31 | 1 | 5 | 0 | 0 | 2 |
| Children 5 through 9 | 48 | 19 | 26 | 0 | 1 | 0 | 0 | 2 |
| Children 10 through 14 | 60 | 33 | 25 | 0 | 2 | 0 | 0 | 0 |
| Children 15 through 19 | 241 | 119 | 111 | 0 | 8 | 0 | 0 | 3 |
| Children 20 through 24 | 400 | 196 | 193 | 1 | 8 | 0 | 0 | 2 |
| Children 0 through 24 | 1454 | 646 | 732 | 5 | 41 | 0 | 0 | 30 |

**Notes - 2011**
Data Source: VSA

**Narrative:**
The all race infant mortality rate was 8.0 per 1,000 live births in 2008. There were large disparities by race, with the Black infant mortality rate 2.6 times higher than the rate among White rates.

In Maryland deaths of infants are reviewed in the Fetal and Infant Mortality Review Programs in all of Maryland's 24 jurisdictions to determine possible systems changes that could prevent a recurrence of the deaths reviewed. These reviews include gathering information from hospital records, face to face interviews with the mothers and final review by a group of experts to assess what happened and if there was anything that could have prevented the loss.

The leading causes of death among children 1 through 17 continue to be unintentional injuries and homicides. Deaths of children 0 through 17 years are reviewed by the local Child Fatality

Review Teams. A State Child Fatality Review (CFR) Team includes a diverse group of experts (see website at http://fha.maryland.gov/mch/cfr_home.cfm). Legislation passed in the 2009 legislative session will permit the sharing of CFR data with the National Center for Child Death Reporting and result in improved data assessment and program implementation.

Local CFR Initiatives include a Teen Driving Task Force, articles in the local newspapers to promote water safety and drowning prevention, a Pediatric Window Falls Task Force, collaboration with the Department of Juvenile Justice to address juvenile crimes, trainings for the local law enforcement on juvenile crime investigation and infant death scene investigation, prevention of shaken baby syndrome (see brochure developed at http://fha.maryland.gov/mch/publications.cfm entitled "When Your Baby Won't Stop Crying") and safe sleep initiatives. The Center for Maternal and Child Health provides funding to the Maryland Center for Infant and Child Loss at the University of Maryland School of Medicine to help them provide bereavement inventions and counseling to families who have experienced a loss.

**Health Status Indicators 08B:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

| **CATEGORY** Total deaths | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Infants 0 to 1 | 580 | 34 | 3 |
| Children 1 through 4 | 80 | 8 | 0 |
| Children 5 through 9 | 46 | 2 | 0 |
| Children 10 through 14 | 59 | 1 | 0 |
| Children 15 through 19 | 225 | 16 | 0 |
| Children 20 through 24 | 367 | 32 | 1 |
| Children 0 through 24 | 1357 | 93 | 4 |

**Notes - 2011**

**Narrative:**
There are many issues related to age and race reflected in Maryland disparities. The incidence of low birth weight (<2500 grams) was 9.1% in 2007. This figure was 7.18% for white infants, 12.9% for black infants and 7.3% for Hispanic infants. The incidence of very low birth weight (<1500 grams) was 1.9% overall, 1.2% for whites, 3.2% for blacks and 1.3% for Hispanics. The infant mortality rate, likewise, was 8.0 per 1000 live births in 2007 with the rate of 4.6 among whites, 14.0 among blacks and 3.8 among Hispanics.

Additionally, the overall age-adjusted death rate for blacks was 1.2 times higher that the rate for whites. Rates were higher among blacks than whites for six of the ten leading causes of death. The largest race differential by cause of death was the HIV disease, with the death rate 23.9 times higher among blacks than whites.

In Maryland deaths of infants children aged 0 through 24 years are reviewed in the Fetal and Infant Mortality Review Programs in all of Maryland's 24 jurisdictions to determine possible systems changes that could prevent a recurrence of the deaths reviewed. These reviews include gathering of information from hospital records, face to face interviews with the mothers and final review by a group of experts to assess what happened and if there was anything that could have

prevented the loss.

Additionally, deaths of children age one year or older are reviewed by the local Child Fatality Review Teams. A State Child Fatality Review (CFR) Team includes a diverse group of experts (see website at http://fha.maryland.gov/mch/cfr_home.cfm). Legislation passed in the 2009 legislative session will permit the sharing of CFR data with the National Center for Child Death Reporting and result in improved data assessment and program implementation.

Local CFR Initiatives include a Teen Driving Task Force, articles in the local newspapers to promote water safety and drowning prevention, a Pediatric Window Falls Task Force, collaboration with the Department of Juvenile Justice to address juvenile crimes, trainings for the local law enforcement on juvenile crime investigation and infant death scene investigation, prevention of shaken baby syndrome (see brochure developed at http://fha.maryland.gov/mch/publications.cfm entitled "When Your Baby Won't Stop Crying") and safe sleep initiatives. The Center for Maternal and Child Health provides $137,799 per state fiscal year for a total of $413,397 to the Maryland Center for Infant and Child Loss at the University of Maryland School of Medicine to help them provide bereavement inventions and counseling to families who have experienced a loss.

**Health Status Indicators 09A:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

| **CATEGORY** Misc Data BY RACE | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** | **Specific Reporting Year** |
|---|---|---|---|---|---|---|---|---|---|
| All children 0 through 19 | 1506879 | 884278 | 494605 | 5874 | 71388 | 1490 | 49244 | 0 | 2008 |
| Percent in household headed by single parent | 33.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2008 |
| Percent in TANF (Grant) families | 15.1 | 7.4 | 28.9 | 8.6 | 6.4 | 7.0 | 0.0 | 0.0 | 2009 |
| Number enrolled in Medicaid | 456181 | 116869 | 235780 | 771 | 11766 | 229 | 0 | 90766 | 2009 |
| Number enrolled in SCHIP | 145311 | 41360 | 59466 | 225 | 6218 | 98 | 0 | 37944 | 2009 |
| Number living in foster home care | 17758 | 4558 | 12160 | 35 | 90 | 7 | 0 | 908 | 2009 |
| Number enrolled in food stamp program | 145358 | 0 | 0 | 0 | 0 | 0 | 0 | 145358 | 2008 |
| Number enrolled in WIC | 112745 | 44328 | 49679 | 996 | 3010 | 327 | 6405 | 8000 | 2009 |
| Rate (per 100,000) of juvenile crime arrests | 3582.8 | 2371.4 | 6637.0 | 308.0 | 418.1 | 0.0 | 0.0 | 0.0 | 2008 |
| Percentage | 2.8 | 2.2 | 3.6 | 4.8 | 1.0 | 0.0 | 0.0 | 0.0 | 2009 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| of high school drop-outs (grade 9 through 12) | | | | | | | | | |

**Notes - 2011**
Data Source: Maryland Asessment Tool for Community Health (MATCH), 2008.

Please Note: The percentage of children in single-parent families is unavailable by race/ethnicity. The total percentag of MD children in single-parent families= 33% of those under the age of 18.
Data Source: The Anne E. Casey Foundation, 2008.

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note:
*The percent of infants and children aged 0-19 years in TANF (grant) families by race, "More than one race reported"--data is currently unavailable.
*The number of infants and children aged 0-19 years in TANF (grant) families by race, "Other and Unknown" = 12,991. However, the percent of infants and children aged 0-19 years in TANF (grant) families by race, "Other and Unknown" is not presented as population data for this category ("Other and Unknown") is currently unavailable.

*Number of infants and children aged 0-19 years in TANF (grant) families by race (Total, White, Black, Native American, Asian, Pacific Islander, Unknown), calendar year 2009.
White – 65,794 infants and children/ (884,278 All children 0 to 19)= 7.4%
Black – 143,091 infants and children/ (494,605 all children 0 to 19)= 28.9%
Native American – 505 infants and children/ (5,874 all children 0 to 19)= 8.6%
Asian – 4,593 infants and children/ (71,388 all children 0 to 19)= 6.4%
Pacific Islander/Alaskan – 104 infants and children/ (1,490 all children 0 to 19)=7%
Unknown – 12,991 infants and children
Total – 227,078 infants and children/ (1,506,879 all children 0 to 19)= 15.1%

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note:
*The number of of children (0-19) enrolled in Medicaid by Race "More than One Race Reported" is currently unavailable.

** The Medicaid Data System records Hispanic Ethnicity as a racial category, therefore 62,866 children of Hispanic ethnicity are included in the total for Unknown race, in order for the total number enrolled in Medicaid to be correct.

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note:
*The number of of children (0-19) enrolled in SCHIP by Race "More than One Race Reported" is currently unavailable.

** The Medicaid data system records Hispanic as a racial category, therefore 31,111 Hispanic children have been included in the Unknown racial category in order that the Total Enrollment value will be correct.

Please Note: Most recent 2009 data is unavailable. The number of children enrolled in food stamp program is unavailable by race/ethnicity.
Data Source: Department of Human Resources, 2008.

Data Source: Maryland WIC Program, as of 12/2009.

Data Source: Maryland State Police--Juvenile Crime Arrests, 2008.

*Rate (per 100,000) of juvenile crime arrests
---The total number of juvenile arrests (<18 yrs)= 48,030.
Juvenile arrests data by race: White= 18,607; Black= 29,138; American Indian=16; Asian=269.
Population data:

---Total population (<18 yrs)= 1,340,583.
Total population (<18 yrs) by race: White Alone (<18 yrs)= 784,644; Black Alone (<18 yrs)= 439,021; American Indian/Alaskan Native Alone (<18 yrs)= 5,196; Asian Alone (<18 yrs)= 64,333.

*Please Note: Juvenile crime arrests data (by race) is unavailable for “Native Hawaiian or Other Pacific Islander”, “More than one race reported”, and “Other and Unknown.”

Please Note: The percentage of Native Hawaiian or other Pacific Islander high school dropouts is unavailable.

Data Source: Maryland State Department of Education (MSDE) www.mdreportcard.org , 2009

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note:
*The number of of children (0-19) living in foster home care by Race "More than One Race Reported" is currently unavailable.

Number of infants and children (0-19 years) living in foster home care by race (Total, White, Black, Native American, Asian, Pacific Islander, Unknown), calendar year 2009.
White –4,558 infants and children; Black –12,160 infants and children; Native American –35 infants and children; Asian – 90 infants and children; Pacific Islander/Alaskan – 7 infants and children; Unknown – 908 infants and children; Total –17,758 infants and children

Note that these data reflect cumulative numbers of children in subsidized adoptions (~10,000), in addition to those in foster care. Medicaid is unable to disaggregate only those in foster care.

**Narrative:**
In today's failing economy families are in crisis from lost jobs and the loss of health insurance that may have been provided by these jobs. The unemployment rate in Maryland in 2009 was 7% and the rate continues to increase. Federal, state and local programs have been called on to meet the need for increasing services while facing cuts of their own. Adverse outcomes disproportionately affect infants and children in foster care (over 17,000 children) or in single parent homes. Single adult women are nearly twice as likely to be uninsured as married women. Children less than 19 years of age comprise 18% of the uninsured.

Additionally, when families are in crisis it follows that there is an increase in family violence and abuse and neglect of children. The Department of Human Resources is spearheading a three year effort to bolster 1000 new foster families by 2010 so that children can live in closer proximity to family members and their communities. Crime increased in Maryland by 2% in 2008, although

violent crime decreased by 2%. Leaving high school before graduation can lead to continued poverty and higher incidence of juvenile arrests. In Maryland the graduation rate is 85%, slightly higher that the national average.

Many infants and children eligible for Medicaid and other State programs are not enrolled. Outreach efforts are underway at both the state and local levels to meet this challenge.

**Health Status Indicators 09B:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

| **CATEGORY** Miscellaneous Data BY HISPANIC ETHNICITY | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** | **Specific Reporting Year** |
|---|---|---|---|---|
| All children 0 through 19 | 1369254 | 137625 | 0 | 2008 |
| Percent in household headed by single parent | 0.0 | 0.0 | 33.0 | 2008 |
| Percent in TANF (Grant) families | 14.2 | 10.7 | 0.0 | 2009 |
| Number enrolled in Medicaid | 393315 | 62866 | 0 | 2009 |
| Number enrolled in SCHIP | 114200 | 31111 | 0 | 2009 |
| Number living in foster home care | 16850 | 397 | 0 | 2009 |
| Number enrolled in food stamp program | 0 | 0 | 145358 | 2008 |
| Number enrolled in WIC | 80509 | 32236 | 0 | 2009 |
| Rate (per 100,000) of juvenile crime arrests | 3582.8 | 0.0 | 0.0 | 2008 |
| Percentage of high school drop-outs (grade 9 through 12) | 2.8 | 3.7 | 0.0 | 2009 |

**Notes - 2011**
Data Source: Maryland Asessment Tool for Community Health (MATCH), 2008.

Please Note: The percentage of children in single-parent families is unavailable by race/ethnicity. The total number of children in single-parent families= 414,000.
Data Source: The Anne E. Casey Foundation, 2008.

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note:
*The number of infants and children aged 0-19 years in TANF (grant) families by ethnicity, "Unknown" = 12,991. However, the percent of infants and children aged 0-19 years in TANF (grant) families by ethnicity, "Ethnicity Not Reported" is not presented as population data for this category ("Ethnicity Not Reported") is currently unavailable.

Number of infants and children aged 0-19 years in TANF (grant) families by Hispanic ethnicity (total non-Hispanic, total Hispanic, ethnicity not reported), calendar year 2009.
Hispanic – 14,702 infants and children/ (137,625 Total Children Hispanic or Latino)= 10.7%
Non-Hispanic – 214,087 infants and children/(1,506,879 Total children NOT Hispanic of Latino)=14.2%
Unknown – 12,991 infants and children
Total – 241,780 infants and children

Data Source:  The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note:
*The number of of children (0-19) enrolled in Medicaid by Ethnicity "Ethnicity Not Reported" is currently unavailable.

Number of children (0-19 years) enrolled in Medicaid (non-MCHP or MCHP Premium) by Ethnicity (Total non-Hispanic, total Hispanic) for calendar year 2009.
Hispanic – 62,866 children; Non-Hispanic – 393,315 children; Total – 456,181 children

Data Source:  The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note:
*The number of of children (0-19) enrolled in Medicaid by Ethnicity "Ethnicity Not Reported" is currently unavailable.

Number of children (0-19 years) enrolled in MCHP or MCHP Premium by Ethnicity (Total non-Hispanic, total Hispanic) for calendar year 2009.
Hispanic –31,111 children; Non-Hispanic –114,200 children; Total –145,311 children

Please Note: Most recent 2009 data is unavailable. The number of children enrolled in food stamp program is unavailable by race/ethnicity.
Data Source: Department of Human Resources, 2008.

Data Source: Maryland WIC Program, as of 12/2009.

*Please Note: Juvenile crime arrests data (by ethnicity) is unavailable for “Total NOT Hispanic or Latino”, “Total Hispanic or Latino”, and “Ethnicity Not Reported.”

Data Source: Maryland State Police--Juvenile Crime Arrests, 2008.

Please Note: The percentage of "Ethnicity Not Reported" high school dropouts is unavailable.

Data Source: Maryland State Department of Education (MSDE) www.mdreportcard.org , 2009

Data Source:  The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note:
*The number of of children (0-19) living in foster home care by Ethnicity "Ethnicity Not Reported" is currently unavailable.

Number of infants and children (0-19 years) living in foster home care by Hispanic ethnicity (total non-Hispanic, total Hispanic, ethnicity not reported), calendar year 2009.
Hispanic – 397 infants and children; Non-Hispanic – 16,850 infants and children; Unknown – 908 infants and children; Total –18,155 infants and children

**Narrative:**
In today's failing economy families are in crisis from lost jobs and the health insurance than may have been provided by these jobs. The unemployment rate in Maryland is at 7.2% and the future continues to look bleak. Federal, state and local programs have been called on the meet the need for increasing services that are just not able to provide while facing cuts of their own. Adverse outcomes disproportionately affect infants and children in foster care (some 9600 children) or in

single parent homes. Among women ages 19-44 and 45064, single women are about twice as likely to be uninsured as married women in the same age group. Adults without dependent children younger that age 19 comprises the majority (58%) of Maryland's uninsured, and most of them are single. Children are 20% of the uninsured, and you adults (single or married) are 42%.

Additionally, when families are in crisis it follows that there is an increase in family violence and abuse and neglect of children. The Department of Human Resources is spearheading a three year effort to bolster 1000 new foster families by 2010 so that children can live in closer proximity to family members and their communities. Crime, too, is on the increase in metropolitan areas like Baltimore City and the greater metropolitan areas surrounding Washington, DC. Leaving high school before graduation can lead to continued poverty and higher incidence of juvenile arrests. In Maryland the graduation rate is 73%, slightly higher that the national average.

Many infants and children eligible fro Medicaid and other State programs are not enrolled. Outreach efforts are underway at both the state and local levels to meet this challenge.

## Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

| Geographic Living Area | Total |
|---|---|
| Living in metropolitan areas | 893400 |
| Living in urban areas | 176672 |
| Living in rural areas | 436807 |
| Living in frontier areas | 0 |
| **Total** - all children 0 through 19 | 613479 |

**Notes - 2011**
Classification of Mertropolitan areas based on Maryland Annotated Code. Metropolitan areas( in Maryland) include: Anne Arundel, Baltimore, Howard, Montgomery, and Prince George's counties.
Data Source: Resident population 0-19 years, 2008
MD DHMH, FHA, MATCH

Classification of Urban areas based on Maryland Annotated Code. Urban areas( in Maryland) include: Baltimore City.
Data Source: Resident population 0-19 years, 2008
MD DHMH, FHA, MATCH

Classification of Rural areas based on Maryland Annotated Code. Rural areas( in Maryland) include: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washignton, Wicomicico, Worcester, and Carroll counties.
Data Source: Resident population 0-19 years, 2008.
MD DHMH, FHA, MATCH

Please Note: Data for 2009 is currently unavailable. Frontier data is n/a.

**Narrative:**
In today's failing economy families are in crisis from lost jobs and the health insurance than may have been provided by these jobs. The unemployment rate in Maryland is at 7.2% and the future continues to look bleak. Federal, state and local programs have been called on the meet the need for increasing services that are just not able to provide while facing cuts of their own. Adverse

outcomes disproportionately affect infants and children in foster care (some 9600 children) or in single parent homes. Among women ages 19-44 and 45064, single women are about twice as likely to be uninsured as married women in the same age group. Adults without dependent children younger that age 19 comprises the majority (58%) of Maryland's uninsured, and most of them are single. Children are 20% of the uninsured, and you adults (single or married) are 42%.

Additionally, when families are in crisis it follows that there is an increase in family violence and abuse and neglect of children. The Department of Human Resources is spearheading a three year effort to bolster 1000 new foster families by 2010 so that children can live in closer proximity to family members and their communities. Crime, too, is on the increase in metropolitan areas like Baltimore City and the greater metropolitan areas surrounding Washington, DC. Leaving high school before graduation can lead to continued poverty and higher incidence of juvenile arrests. In Maryland the graduation rate is 73%, slightly higher that the national average.

Many infants and children eligible fro Medicaid and other State programs are not enrolled. Outreach efforts are underway at both the state and local levels to meet this challenge.

**Health Status Indicators 11:** *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---|---|
| Total Population | 5528000.0 |
| Percent Below: 50% of poverty | 0.0 |
| 100% of poverty | 8.7 |
| 200% of poverty | 23.3 |

**Notes - 2011**
Please Note: Data for 2009 is currently unavailable.
Data Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.

Please Note: Data for percent of the population below- 50% of poverty level is currently unavailable.

Please Note: Data for 2009 is currently unavailable.
-Number of residents, below 100% of poverty level= 481,000 (8.7%)
Data Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.
POV46. Poverty Status by State

Please Note: Data for 2009 is currently unavailable.
-Number of residents, below 200% of poverty level= 1,290,000 (23.3%)
Data Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.
POV46. Poverty Status by State

**Narrative:**
Title V funds do not directly affect the geographic location of children whether rural, Metropolitan or urban. However, barrier and access to care may be influenced by geographic location. The provision of programs including outreach clinics and telemedicine would positively influence the health of those living in areas of limited access.

**Health Status Indicators 12:** *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---|---|
| Children 0 through 19 years old | 1333000.0 |
| Percent Below: 50% of poverty | 0.0 |
| 100% of poverty | 10.0 |
| 200% of poverty | 28.3 |

**Notes - 2011**
Please Note: Data for 2009 is currently unavailable.
-Data is for child population, Under 18 Years of Age.
Data Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.

Please Note: Data for percent of the population (0 to 19) below- 50% of poverty level is currently unavailable.

Please Note: Data for 2009 is currently unavailable.
-Data is for population Under 18 Years of Age.
Number of residents (0 to 18) below 100% of poverty level= 133,000 (10%)
Data Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.
POV46. Poverty Status by State

Please Note: Data for 2009 is currently unavailable.
-Data is for child population, Under 18 Years of Age.
Number of residents (0 to 18), below 200% of poverty level= 377,000 (28.3%)
Data Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.
POV46. Poverty Status by State

**Narrative:**
Title V funds do not directly affect the poverty level of the population. Poverty has been shown to impact the health of a population. The availability of health insurance is important to allow access to care for those living in poverty. During the 2007 Special Legislative Session, Senate Bill 6 was passed, which provides for Medical Assistance to parents and other family members caring for children with incomes up to 116% of the Federal Poverty Level. In Fiscal Year 2009, the Medical Assistance for Families initiative was launched. On July 1, 2008, Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about $21,200 for a family of three. There is no asset limit when applying, no face-to-face interview is required and there are options to apply online, by mail or by fax. The number of families now on the new program has exceeded 45,000.

## F. Other Program Activities

MCH Hotline/Children's Resource Line: The MCH/Medicaid Programs operate an 800 number telephone line for MCH outreach, information and referral (1-800-456-8900). This line is located and operated by the Medical Assistance Program and is used to provide information and education about the Medical Assistance Program as well as to refer callers to MCH providers.

Web Sites: Both the Center for Maternal and Child Health (www.fha.state.md.us/mch) and the Office for Genetics and Children with Special Health Care Needs (www.fha.state.md.us/genetics) provide functional Websites. These web sites include information about all programs funded or provided, as well as information about the Title V program, including linkage to a copy of the complete Title V report for the most recent fiscal year.

Child Abuse and Neglect: The Legislature charged DHMH to establish a Child Abuse and Neglect Center of Excellence Initiative within DHMH. Responsibility for administering this Initiative was placed within CMCH. The Center of Excellence trains providers in each region of the State to diagnose and treat child abuse and neglect. Legislation passed in 2006 establishes the Children's Trust Fund under DHMH to fund the Child Abuse and Neglect Centers of Excellence using funds derived from the sale of commemorative birth certificates. CMCH recently revised and updated the Commemorative Birth Certificate brochure promotes the Children's Trust Fund.

Emergency Preparedness: Emergency preparedness is an important priority concern for DHMH. DHMH recently consolidated the Office of Public Health Response and the Office of Emergency Response into a single unit reporting directly to the Deputy Secretary for Public Health. This was done to ensure that activities are coordinated. CMCH has also began to prepare for a range of emergency situations that would benefit from a coordinated MCH approach. A CMCH protocol has been developed and staff are continuing to meet to discuss the role of MCH within the DHMH emergency preparedness program. Title V will continue to take an active role in promoting H1N1 vaccinations.

Conferences and Training: The MCH Program recognizes the importance of enhancing public health competency through ongoing training and education. It achieves this activity by providing training opportunities to LHD public health personnel in important MCH domains such as home visiting, school and adolescent health, screenings and surveillance and asthma education. Several conferences are annually supported by the MCH Program. These include the annual reproductive health update, the annual school health institute, an asthma summit, a perinatal health conference, and technical assistance workshops for local health departments. Meetings that address strategic planning for Title V are planned for FY 2011.

Women's Health: An Office of Women's Health was established within CMCH in 2001 with the goal of promoting wellness for Maryland women throughout the lifespan. Activities of this Office include the publication and dissemination of reports (e.g., chartbook on the heath status of Maryland women; postpartum depression); promotion of inter and intra-agency coordination on women's health issues, and implementation of a statewide model for integrating preventive health screening into family planning programs. CMCH hosted the annual Women's Health Steering Committee meeting in May 2010. Findings from the 2008 PRAMS report was highlighted.

Sudden Infant Death Syndrome: Title V monies will continue to support the Maryland SIDS Project at the Center for Infant and Child Loss, University of Maryland School of Medicine. This Center provides SIDS outreach and education as well as counseling to support families experiencing the death of a child.

Environmental Health Tracking System: The Community Health Administration continued to work with the Environmental Public Health Tracking Program's network implementation grant from the CDC. The Family Health Administration, including CMCH and OGCSHCN, will be involved in grant development. The grant references the need for collaboration with a variety of data sources important to Title V including the birth defects registry, hospital discharge data, vital statistics and the childhood lead registry. CMCH provides staff support for the Children's Environmental Health

Advisory Council and worked to complete a Children's Environmental Health Indicator Report.

The OGCSHCN is working with the Environmental Public Health Tracking Program' to post data on birth defects for public uses on the web as per the CDC protocol. The Maryland Tracking Network went live and displays birth defects data.

Autism Spectrum Disorders: During the 2005 session, legislation was passed requiring the Maryland Dept of Education, in collaboration with the Maryland Dept of Health and Mental Hygiene, to establish a pilot program to study and improve screening practices for Autism Spectrum Disorders. OGCSHCN sits on the Advisory Council overseeing the implementation of this legislation. Title V has participated in several meetings focused on Autism Spectrum Disorders.

OGCSHCN is also funding Baltimore City to pilot a quality improvement initiative for developmental screening in 2 pediatric practices.

## G. Technical Assistance

The state of Maryland is not submitting a technical assistance request at this time. Technical assistance needs may be discussed at the August review meeting with the Maternal and Child Health Bureau.

# V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

| | FY 2009 | | FY 2010 | | FY 2011 | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **1. Federal Allocation** *(Line1, Form 2)* | 11931558 | 11931558 | 11955050 | | 11953971 | |
| **2. Unobligated Balance** *(Line2, Form 2)* | 0 | 0 | 0 | | 0 | |
| **3. State Funds** *(Line3, Form 2)* | 8948669 | 8948669 | 8966288 | | 8965479 | |
| **4. Local MCH Funds** *(Line4, Form 2)* | 0 | 0 | 0 | | 0 | |
| **5. Other Funds** *(Line5, Form 2)* | 0 | 0 | 0 | | 0 | |
| **6. Program Income** *(Line6, Form 2)* | 0 | 0 | 0 | | 0 | |
| **7. Subtotal** | 20880227 | 20880227 | 20921338 | | 20919450 | |
| **8. Other Federal Funds** *(Line10, Form 2)* | 105935463 | 105935463 | 113707133 | | 129454241 | |
| **9. Total** *(Line11, Form 2)* | 126815690 | 126815690 | 134628471 | | 150373691 | |

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2009 | | FY 2010 | | FY 2011 | |
|---|---|---|---|---|---|---|
| **I. Federal-State MCH Block Grant Partnership** | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **a. Pregnant Women** | 2456960 | 2456960 | 2971107 | | 2586320 | |
| **b. Infants < 1 year old** | 2868135 | 2868135 | 2830478 | | 2802689 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **c. Children 1 to 22 years old** | 8987629 | 8987629 | 8936427 | | 8577383 | |
| **d. Children with Special Healthcare Needs** | 5594080 | 5594080 | 5805320 | | 5589845 | |
| **e. Others** | 629637 | 629637 | 0 | | 1003213 | |
| **f. Administration** | 343786 | 343786 | 378006 | | 360000 | |
| **g. SUBTOTAL** | 20880227 | 20880227 | 20921338 | | 20919450 | |
| **II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).** | | | | | | |
| **a. SPRANS** | 289172 | | 224511 | | 437274 | |
| **b. SSDI** | 94644 | | 94644 | | 93713 | |
| **c. CISS** | 0 | | 0 | | 0 | |
| **d. Abstinence Education** | 569676 | | 0 | | 0 | |
| **e. Healthy Start** | 0 | | 0 | | 0 | |
| **f. EMSC** | 0 | | 0 | | 0 | |
| **g. WIC** | 88576661 | | 96900831 | | 112043869 | |
| **h. AIDS** | 0 | | 0 | | 0 | |
| **i. CDC** | 8298035 | | 8283512 | | 8546040 | |
| **j. Education** | 0 | | 0 | | 0 | |
| **k. Other** | | | | | | |
| **Family Planning** | 3991508 | | 0 | | 4307837 | |
| **Injury** | 1467042 | | 0 | | 1387061 | |
| **Preventive Health S** | 0 | | 0 | | 2032809 | |
| **Primary Care/Rura** | 0 | | 0 | | 605638 | |
| **FP/Injury** | 0 | | 5632822 | | 0 | |
| **PCR/PHHS** | 0 | | 2570813 | | 0 | |
| **Preventive Health BG** | 1985279 | | 0 | | 0 | |
| **Primary Care/Rural H** | 663446 | | 0 | | 0 | |

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

| | **FY 2009** | | **FY 2010** | | **FY 2011** | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **I. Direct Health Care Services** | 1583511 | 1583511 | 1571270 | | 2529026 | |
| **II. Enabling Services** | 7832233 | 7832233 | 6524185 | | 7839371 | |
| **III. Population-Based Services** | 3492527 | 3492527 | 4862982 | | 2850823 | |
| **IV. Infrastructure Building Services** | 7971956 | 7971956 | 7962901 | | 7700230 | |
| **V. Federal-State Title V Block Grant Partnership Total** | 20880227 | 20880227 | 20921338 | | 20919450 | |

## A. Expenditures

This section describes Title V expenditures for FFY 2009 and notes any trends and shifts in expenditures as compared to previous years. During FFY 2009, the Maryland joint federal-state Title V Program expended $20,880,227 for services and activities to promote the health of women, infants, and children including those with special health care needs. With the federal funds, the state met the 30-30-10 budgeting requirement, with 38% of federal funds allocated for children with special health care needs and 47% allocated for preventive and primary care services for children. Less than 10% of federal funds were used for administration.

By level of the MCH pyramid, the majority of Title V -- State partnership funds supported activities at the infrastructure and enabling levels ($15,804,189 or 75.7%). Direct services represented 7.6% of expenditures and included direct medical care for children with special health care needs in tertiary medical and medical day care centers. Direct care services were also provided by family planning clinical providers in several jurisdictions as well as prenatal care and well child care clinical services that continued to be offered by a very limited number of local health departments.

The first notable shift in funding allocation occurs in FY 1999 with the advent of MCHP making children in families with incomes up to 200% FPL eligible for Medicaid services. Direct expenditures went from 61% to 28% in one year. This continued to decrease as Maryland's Medical Assistance Program assumed a greater fiscal role, including covering more CSHCN unique services.

During this same time period, the percentage of expenditures for enabling services also increased. This was due to more local health departments providing care coordination services in lieu of direct services. Most of the current funding for these services has been in prenatal and early infant home visiting of the families most at risk for poor maternal and birth outcomes. This shift also occurred as the State Title V Agency educated and notified local health departments that combined, the majority of Title V dollars, should be allocated for enabling, population-based services and infrastructure development.

Population based services represented 16.7% of expenditures. These services included newborn screening for metabolic disorders, screening for blood lead exposure, immunizations, and vision and hearing screening in the schools.

## B. Budget

Maryland's Maternal and Child Health Block Grant supports vital programs and services for women and children in Maryland, including those with special health care needs. The Title V MCH Program is jointly administered by the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) under the auspices of the Family Health Administration. The Department of Health and Mental Hygiene has a strong commitment to core public health functions and essential public health services to Maryland's families and children.

The Maternal and Child Health Program budgets and functions reflect an evolving public health responsibility that complements and enhances the current health delivery system, recognizes recent legislative changes in health and mandated public health functions, the uniqueness of the populations being served, and emerging research and standards of care affecting the health status of MCH populations. Maryland's Title V budget for FY 2011 totals $20,919,450 including $11,953,971 in federal funds and $8,965,479 in State funds and reflects a decrease in federal block grant funding since 2006. The State share in MCH services meets the requirements for the State match. Maryland meets the maintenance of effort requirement of Sec. 505 (a)(4).

Maryland continues to allocate Maternal and Child Health Block Grant funds using criteria that include: (1) MCH priority needs based on statewide and community assessments, (2) local health department fiscal shortfalls within the identified core categories, (3) poverty rates and estimated size of the maternal and child population (birth-21 years of age), (4) performance measures and outcome measures and (5) the availability of other funding sources. An example of this is the MCHP expansion which enabled funds to be reallocated from direct services for CSHCN to other population groups ineligible for MCHP. Funds may be reallocated throughout the year when unexpected needs are identified. (Budgets are developed two years prior to authorized spending. For example during the summer of 2009, the MCH Budgets for FY 2011 were developed. During the 2010 Legislative Session, the FY 2011 budget was approved).

Throughout the two-year budget process, but particularly during the budget development and the revision phase (based on legislative authorized budget), the MCH Offices evaluate the MCH Service Pyramid fiscal allocation to ensure that it reflects the spirit and intent of MCHB. Throughout the year, quarterly meetings are held between the MCH Offices and the Budget Personnel to determine current expenditure levels and expected expenditure for the remainder of the year. It is during these meetings that budget shortfalls and funds to be reallocated are identified. Throughout the year, all contracts including LHD grants are tracked through the procurement process and subsequently monitored for appropriate and timely expenditures, and adherence to DHMH fiscal procedures.

During the development and subsequent expenditure of the MCH budget, the grant is fiscally and programmatically monitored to ensure that the funding levels adhere to the "30-30-10" Title V requirement. For FFY 2011, it is proposed that funding for each Title V population will be distributed accordingly: preventive and primary care for children -- 41.2%, CSHCN --39.2% and Administration -- 3%. The other category at 16.6% refers to the maternal and infant health population. By level of the MCH pyramid, it proposed that funding will be distributed as follows: direct services - $2,529,026 or 12.1%; enabling services - $7,839,371 or 37.4%; population based -- $2,850,823 or 13.6% and infrastructure building services - $7,700,230 or 36.8%.

In FFY 2011, a total of $8,577,383 in state and federal funds are budgeted to support programs and services for children and adolescents. These funds will support activities that promote and protect the health of Maryland's 1.7 million children and adolescents, ages 0-21, by assuring that comprehensive, quality preventive and primary services are accessible. Activities and strategies will include:

. Early Childhood Initiatives, including home visiting, early childhood mental health and promotion of access to a medical home;
. Childhood Lead Screening Program, which promotes increased blood lead testing, particularly in "at risk" areas;
. The Maryland Asthma Control Program, which includes partnership building and implementation of interventions, planning, and surveillance;
. School health programs, including medical consultation and development of guidelines related to issues such as childhood nutrition and obesity; and provision of screening services; and;
. Child Fatality Review, the goal of which is to prevent child deaths by developing an understanding of the causes and incidence of child deaths.

In FY 2011, a total of $6,392,222 is budgeted for programs and services to prevent maternal and infant deaths and improve the health care system for women of childbearing age and the 75,000+ babies born each year in Maryland. Activities and strategies will include:

. Statewide Perinatal Standards, and perinatal systems building activities in each jurisdiction, including maternal, fetal and infant mortality reviews, and perinatal center review and designation;
. Sudden Infant Death Syndrome (SIDS) educational and family support activities;
. Statewide initiatives (Babies Born Healthy and the Governor's Delivery Unit) to reduce infant

mortality and eliminate racial disparities in birth outcomes;
. A statewide survey to improve pregnancy outcomes (PRAMS);
. Promotion of infant breastfeeding;
. Care coordination services and home visiting for pregnant women and infants;
. Fetal alcohol spectrum disorder (FASD) prevention activities; and
. Family planning/reproductive health clinical services.

In FY 2011, a total of $5,589,845 is budgeted for programs and services to address children with special health care needs. Activities and strategies will include:

. Payment for Medical/Clinical Services
Through the Children's Medical Services Program, payment for direct specialty care and related services is made to providers for uninsured and underinsured children who meet the medical and financial eligibility criteria for the program.

. Genetic Services
Funding is also provided for a statewide system of clinical genetic services, including infrastructure support for 3 Genetics Centers, 14 Outreach Clinics, the Comprehensive Hemophilia Treatment Center, pediatric and transition (adolescent/young adult) Sickle Cell Disease Clinics and specialized biochemical genetics laboratory services.

. Birth Defects Program
The Birth Defects Reporting and Information System (BDRIS) collects data on birth defects to estimate birth defects prevalence, track trends and conduct surveillance for changes in trends that could be related to environmental hazards. BDRIS also uses the full resources of the OGCSHCN to provide families with information and referrals.

. Medical Day Care for CSHCN
Two medical day care programs designed specifically for medically fragile infants and young children are funded by the Program. These unique centers provide skilled nursing services in a child care setting for children ages 6 weeks to 5 years who have complex medical conditions and whose needs cannot be met in traditional child care programs.

. Local Health Department Grants
In addition to funding local health departments for core public health activities, funds are also provided specifically for CSHCN services and programs. Outreach specialty clinics are still funded in some jurisdictions, but most jurisdictions have replaced actual clinics with gap-filling care coordination, outreach, information/referral, dissemination of resource information, and needs assessment activities. The local health departments also administer the respite care funds provided through the local health department grants.

. Respite Programs and Special Camps
Enabling services are growing in Maryland. In addition to the PKU and Sickle Cell Disease camps that have been funded for many years, specialty camps for children with neurofibromatosis and spina bifida are now being supported. Local health departments are now funding a variety of respite services as well as increasing community capacity for providing them with grant funds provided by the OGCSHCN.

. Parent Involvement Activities
Parental involvement in policy and program development is supported through a grant to Parent's Place of Maryland (PPMD), a non-profit, family-directed and staffed center serving parents of children with disabilities and special health care needs. PPMD also houses the Maryland chapter of Family Voices. PPMD and OGCSHCN have an ongoing partnership in a number of activities. These include the Family-to-Family Health Education and Information Center, which provides families of CYSHCN with a central source of information and education about the health care system as well as direct family support and referrals as well as the Maryland Community of Care

Consortium for CSHCN. The Consortium is funded by a grant from the federal Maternal and Child Health Bureau and offers a forum for information exchange, problem solving, consensus building, and collaborative action to address gaps and barriers in services for children with special health care needs (CSHCN) and their families.

. CSHCN Systems-Building Activities
System-building activities include grants to four Centers of Excellence (Johns Hopkins, University of Maryland, Children's National Medical Center, and Kennedy Krieger Institute) to support a Resource Liaison at each center whose function is to assist families of CYSHCN to find needed resources both within the centers and within the community. In some centers, these individuals may work directly with particular clinics and play a greater role in coordinating the care of CYSHCN. Grant funds may also support wraparound services such as nutrition and social work.

. Data Development
Projects include the continued development of in a voluntary, confidential CSHCN database to be used for ongoing needs assessment purposes, and the procurement of enhanced web-based databases for newborn hearing and blood spot (metabolic disorder) screening. The newborn blood spot screening program has implemented an on-line system for primary care providers to look up the screening results on their patients. The infant hearing screening program has initiated and integrated a statewide online data management system for the Maryland Early Hearing Detection and Intervention Program. The online data base allows for virtually real time data sharing which facilitates more timely and accurate follow up and improved continuity of hearing health care.

. Newborn Screening
Newborn screening includes two major programs. The Blood Spot Newborn Screening Program screens newborns for 54 disorders that can cause mental retardation or severe medical problems unless treated soon after birth. (This program also screens for sickle cell disease.) Babies with any screening test result that is not normal are followed up to find out whether they actually have the disorder. Babies with disorders receive appropriate long term treatment and management. The Maryland Early Hearing Detection and Intervention (MD EHDI) Program provides tracking and surveillance of universal newborn hearing screening and follow up. All infants born in Maryland undergo hearing screening to facilitate early identification and intervention for hearing loss. Babies that do not pass their screening or are identified as at risk for late onset hearing loss are followed to ensure appropriate diagnostic and intervention services are received. Screening services for expectant mothers include AFP/Multiple Marker screening for the detection of neural tube defects and certain chromosomal anomalies. Carrier screening is offered for the hemoglobinopathies, Tay-Sachs Disease, and other diseases at high incidence in specific populations.

## VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

## VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. Technical Note
Please refer to Section IX of the Guidance.

## X. Appendices and State Supporting documents
### A. Needs Assessment
Please refer to Section II attachments, if provided.

### B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

### C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

### D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.